Supreme Court, U.S.
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No. 94-___

In The

Supreme Court of the United States

October Term 1994

MICHAEL HOGUE and CAROL HOGUE,

Petitioners,

v.

UNITED OLYMPIC LIFE INSURANCE COMPANY, DELAWARE ADMINISTRATORS, and CONSULTANTS & ADMINISTRATORS, INC.,

Respondents.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Relying on Fed. R. Civ. P. 81(c), the trial court struck the Hogues' jury demand. The jury demand was, however, timely under Fed. R. Civ. P. 38(b) because it was filed "not later than ten days" after the defendants' answer. When a case is removed before the defendant answers, should Rule 81(c) be applied to shorten the time a party would otherwise have to request a jury pursuant to Rule 38(b)?

2. This case was initially removed as a federal question pursuant to ERISA. The Hogues filed a motion to remand asserting that ERISA did not apply since the insurance at issue was not provided as an employee benefit. Defendants then filed a supplemental notice of removal on the basis of diversity. The Hogues filed their jury demand on the same day as the supplemental notice of removal. The trial court retained jurisdiction on the basis of diversity finding that the defendants failed to establish that this was an ERISA case. Since the Hogues filed their jury demand within ten (10) days of the supplemental notice, was their request timely?

3. Whether an insurance company, after a person is stricken with cancer, may raise that person's premium to an exorbitant and unaffordable level, cancel the insurance policy when the person cannot pay the premiums, and refuse to provide coverage for that person's cancer treatment.

4. The Fifth Circuit relied on its prior holding in *Thrash v. State Farm Fire & Casualty Co.*, 992 F.2d 1354 (5th Cir. 1993) to determine that the duty of good faith and

QUESTIONS PRESENTED – Continued

fair dealing under Texas law did not extend to the cancellation of insurance. In *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278, 283 (Tex. 1994), the Texas Supreme Court expressly held that the duty of good faith and fair dealing applies to the cancellation of an insurance policy. May the Fifth Circuit follow its prior interpretation of Texas law when that interpretation conflicts directly with a more recent and controlling decision of Texas' highest court?

5. The last sentence of Tex. Ins. Code art. 3.70-3(B)(6) provides that: "Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation". Similar language has been interpreted by both the Fifth Circuit and the Texas courts as providing that the right to benefits vests when a covered condition occurs while the individual is insured. The Fifth Circuit held this provision to be inapplicable by finding the Hogues were insured as members of a group pursuant to Tex. Ins. Code art. 3.51-6 § 1(a)(2). There was no evidence that the Hogues' insurance met the statutory definition of group insurance. Is the Fifth Circuit's holding that the Hogues were insured with group insurance so erroneous as to call for an exercise of this Court's power of supervision?

6. Was it unconscionable for United Olympic to unilaterally decide to segregate the profitable policyholders from the unprofitable ones and exact exponentially larger premium increases on the unprofitable ones, all while concealing this course of action from anyone making inquiry?

QUESTIONS PRESENTED – Continued

7. The Fifth Circuit held that certain misrepresentations were merely puffing and, relying on *Presidio Enterprises v. Warner Brothers*, 784 F.2d 674, 686 (5th Cir. 1986), found those statements were not actionable. Not only were the representations sufficiently specific to be actionable, *Presidio* is of doubtful precedential value given the subsequent development of Texas law. Is the Fifth Circuit's holding that the statements at issue were puffing and not actionable so contrary to Texas law as to call for an exercise of this Court's power of supervision?

8. The Fifth Circuit found that the Hogues failed to prove that the Defendants made actionable misrepresentations or that the Defendants' conduct was unconscionable. If the striking of the Hogues' jury demand was improper, would these not be questions of fact for the jury to determine?

9. The Hogues claimed that United Olympic's conduct discriminated against them in violation of Tex. Ins. Code art. 21.21 § 4(7)(b). The lower courts found there to have been no discrimination based on the definition of the "class" of policyholders to which the Hogues were found to belong. Several documents were introduced evidencing that the Defendants defined the "class" in which their insureds were situated based on age, sex, geographic location, and benefit package. The trial court and the Fifth Circuit concluded that the Hogues' class was actually policyholders with similar medical conditions. Was the error in defining the "class" of insureds to which the Hogues belonged sufficient to call for an exercise of this Court's power of supervision?

LIST OF PARTIES

The undersigned counsel of record certifies that the following persons have an interest in the outcome of this case.

A. Michael and Carol Hogue, Petitioners;

B. J. Bennett White; Wilson, Sheehy, Knowles, Robertson & Cornelius, P.C. and Joe K. Longley, Longley & Maxwell, L.L.P., Counsel for Petitioners;

C. United Olympic Life Insurance Company, Delaware Administrators, and Consultants & Administrators, Inc., Respondents;

D. Andrew G. Jubinsky, Baxter W. Banowsky, Timothy A. Daniels, Figari & Davenport, L.L.P., Counsel for Respondents;

E. United Services Life Insurance Company, parent corporation of United Olympic Life Insurance Company.

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UNITED OLYMPIC LIFE INSURANCE COMPANY, DELAWARE ADMINISTRATORS, and CONSULTANTS & ADMINISTRATORS, INC.,

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Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

Petitioners Michael and Carol Hogue respectfully pray that the Supreme Court grant a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit rendered on December 7, 1994.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is reported as *Michael Hogue and Carol*

Hogue v. United Olympic Life Ins. Co., Delaware Administrators, and Consultants & Administrators, Inc., 39 F.3d 98 (5th Cir. 1994). (App. A). The Hogues timely filed a motion for rehearing which was denied on January 9, 1995. (App. B). The case was tried non-jury in the United States District Court for the Eastern District of Texas before United States Magistrate Judge Judith K. Guthrie. The trial court's initial Memorandum Opinion was issued on August 12, 1993. The Hogues filed a motion for new trial and for additional findings. In denying the motion for new trial and granting in part the motion for additional findings, the trial court issued its unpublished Memorandum Opinion containing Findings of Fact and Conclusions of Law (App. C) and its Memorandum Order dated September 24, 1993. (App. D).

Also attached are the trial court's order granting the defendants' motion to strike the Hogues' jury demand (App. E), order denying the Hogues' motion to remand (App. F), and the judgment (App. G).

JURISDICTION

This Court's jurisdiction is invoked pursuant to 28 U.S.C. § 1254(1). This petition is timely filed pursuant to 28 U.S.C. § 2101(c).

STATUTES INVOLVED

This case involves the following constitutional provisions, statutes, and rules: Seventh Amendment, United

States Constitution; Federal Rules of Civil Procedure 38(b) and 81(c); articles 3.51-6 § 1(a), 3.70-3(B)(6), 21.21 § 1, 21.21 § 4(7)(b), and 21.21 § 16 of the Texas Insurance Code; §§ 17.44, 17.45(5), 17.46, and 17.50(a)(1) of the Texas Business and Commerce Code. The text of each is set forth in Appendix H.

STATEMENT OF THE CASE

In September 1989, Michael Hogue was diagnosed with Stage IV Hodgkin's disease. He had previously suffered from prostate problems and rheumatoid arthritis. At that time, he and his wife were insured by George Washington Life Insurance Company ("George Washington"). George Washington subsequently went out of business and United Olympic Life Insurance Company ("United Olympic") assumed their insurance coverage. Prior to being insured by George Washington, the Hogues were insured by G.I.C. Insurance Company ("GIC"). The GIC policy purports to be a group policy and, although it does not identify the actual policyholder, it implies that World Wide Consumer Association, Inc. is the policyholder. Mr. Hogue received treatment for his Hodgkin's disease and his claims were paid by United Olympic.

In July 1990, the Hogues' medical premium was raised from $192 per month to $224.56, an increase of 18%. In November 1990, the Hogues were notified that, effective February 1, 1991, their benefits were to be modified from reimbursement of 80% of the first $5,000 of eligible expenses and 100% thereafter to 60% of the first $10,000. This increased their out-of-pocket exposure by

$3,000. Then, in January 1991, before the benefit reductions even took effect, the Hogues were advised that on March 1, 1991, the medical portion of their premium would increase by 413% to $1,151.99 per month. A chart of these policy changes is set out in Appendix I.

The Hogues could not afford the March 1991 premium increase, so they chose not to pay the February 1991 payment since it would only buy them one month's additional coverage at a greatly reduced benefit. When the Hogues failed to pay their February premium, their coverage was terminated. They continued to file claims for Mr. Hogue's Hodgkin's disease, rheumatoid arthritis, and prostate problems, but the defendants denied coverage and refused to pay any additional benefits. The Hogues tried to obtain replacement insurance, but Mr. Hogue was uninsurable due to the existence of his Hodgkin's disease.

On August 11, 1992, the Hogues sued in state court. The defendants filed a notice of removal on September 18, 1992, alleging federal question jurisdiction under ERISA. The defendants answered on September 23, 1992. The Hogues moved to remand, asserting that since their insurance policy was purchased by them individually and not as an employee benefit, there was no federal question jurisdiction. On October 6, 1992, defendants filed a supplemental notice of removal contending that diversity jurisdiction existed. On that same day and within ten days of defendants' answer, the Hogues filed

their jury demand. Ultimately, the district court ruled that it had diversity jurisdiction. (App. F-3).[1]

The defendants consistently maintained that the premium increases and benefit reductions were being uniformly applied to all policyholders. In various letters written by defendants, they represented that: "[t]hese increases vary according to the economic and geographic locations of the employers" and "on the whole, all employers in the trust have received large rate increases" (App. J-1); "[t]he information that is utilized in the calculation of these increases includes the duration of time the individual insured is covered by the plan, his geographic location, and the experience of the entire association" (App. K-1); "[t]he rate increases attempted to place all insureds at the same level, reflecting age/sex/geographic factors" (App. L-2); "[t]he entire group of people in the same class (same: age/sex/geographic location/benefit package) were subject to the same actions" (App. M-1); "the entire Ohio multiple employer trust received the same increase in its health insurance premiums" (App. N-2). The Hogues later learned that these statements were not true. During 1990, the defendants decided to split the group of policyholders into two subclasses. Those who had filed claims less than 80% of their paid premiums were profitable and were secretly moved into a "new trust". Those policyholders whose claims exceeded 80% of their premiums, including the Hogues, were left in the "old trust". Policyholders in the new trust did not

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[1] The trial court's jurisdiction was pursuant to 28 U.S.C. § 1332. The court of appeals' jurisdiction was pursuant to 28 U.S.C. §§ 1291 and 636(c)(3).

have their benefits reduced and their premiums were only raised by 30%. United Olympic's chief actuary, Mr. James P.A. Knight, testified that it was United Olympic's intent to set different rates based solely on the plus-or-minus 80% standard and that no decisions were based upon the individual characteristics of policyholders such as the Hogues.

As is evidenced by the letters in Appendices J through N, the new trust/old trust scheme was concealed from anyone making inquiry. Whenever asked about the exorbitant premium increases being levied on people in the "old trust", the defendants simply responded that all insureds in the same "class", as defined by age/sex/geographic location/benefit package, were treated alike. (*See, e.g.*, App. M-1). No mention was made of the fact that profitable policyholders were being given preferential treatment.

In conjunction with the inception of United Olympic's insurance coverage, the Hogues received three letters representing the quality of insurance they would be provided. The first letter stated that their new insurance company was an "A+ Superior" rated carrier and that "[w]hile many other insurance companies are being forced to announce unreasonable increases in premiums and reduction of benefits, we hope you can share in a positive development of this magnitude". (App. O-2). The second letter assures the Hogues that United Olympic has "a history or reliability and fairness". (App. P-1). The third letter pledges that "future rates and benefits will stabilize". (App. Q-1). Although the second letter indicates that pre-existing conditions would remain the responsibility of George Washington, the evidence was

that Mrs. Hogue was assured that United Olympic would be assuming liability for all pre-existing conditions; furthermore, United Olympic waived any right to rely on that provision by paying for the Hogues' medical expenses once they began filing claims.

In affirming the judgment of the trial court, the Fifth Circuit panel held in a cursory three-page opinion that:

- the Hogues were not discriminated against under Tex. Ins. Code art. 21.21 § 4(7)(b) because they failed to offer evidence that other insureds who received different premiums or benefits were of essentially the same class;
- it was not unconscionable for the defendants to unilaterally bifurcate the trust by segregating the profitable policyholders from the unprofitable ones;
- that the representations concerning the quality of United Olympic were mere puffery and, as such, were not actionable;
- that the Hogues were insured as members of a group as defined by Tex. Ins. Code art. 3.51-6 § 1(a)(1-5); therefore, Tex. Ins. Code art. 3.70-3(B)(6) providing for the continuation of benefits for conditions occurring prior to cancellation was not applicable to them;
- that the duty of good faith and fair dealing applies only when the insurer unjustifiably denies or delays the payment of claims;
- that the Hogues' jury demand was untimely pursuant to Fed. R. Civ. P. 81(c) and that they have waived their argument that the demand was timely pursuant to Fed. R. Civ. P. 38(b)

by raising that argument for the first time on appeal.

REASONS FOR GRANTING THE WRIT

1. This Court Should Grant Certiorari to Vindicate the Hogues' Right to a Jury Trial.

Time and again this Court has declared that the right to a trial by jury is fundamental and that the courts, therefore, should indulge every reasonable inference against its waiver. *Aetna Ins. Co. v. Kennedy*, 301 U.S. 389, 393, 57 S.Ct. 809, 811-12, 81 L.Ed. 1177 (1937); *Pradier v. Elespuru*, 641 F.2d 808, 811 (9th Cir. 1981); *White v. McGinnis*, 903 F.2d 699, 703 (9th Cir.) (en banc), *cert. denied*, 498 U.S. 903, 111 S.Ct. 266, 112 L.Ed.2d 226 (1990). *Rogers v. Missouri Pacific R.R. Co.*, 352 U.S. 500, 509, 77 S.Ct. 443, 450, 1 L.Ed.2d 493 (1957), declared "this Court is vigilant to exercise its power of review in any case where it appears that the litigants have been improperly deprived of [a jury] determination". Even the Fifth Circuit has stated "the right of a jury trial, if not waived but denied after demand, the judge usurping the function of the jury, would seem to be similarly an unconstitutional abuse of power". *Bass v. Hoagland*, 172 F.2d 205, 209 (5th Cir.), *cert. denied*, 338 U.S. 816, 70 S.Ct. 57, 94 L.Ed.2d 494 (1949); *see also Swofford v. B & W, Inc.*, 336 F.2d 406, 409 (5th Cir. 1964), *cert. denied*, 379 U.S. 962, 85 S.Ct. 853, 13 L.Ed.2d 557 (1965). In this case, the Fifth Circuit's actions directly contradict such declarations. Where a litigant is improperly denied his or her right to a jury trial, the correct remedy is for the case to be remanded. *Aetna, supra; Pradier, supra.*

In ruling that the Hogues' jury demand was untimely, the Fifth Circuit has virtually ignored every argument asserted on their behalf. The Hogues initially argued that there is no obligation to file a jury demand pursuant to Fed. R. Civ. P. 81(c) where the removal is sought on defective grounds. Had no supplemental notice of removal been filed, the case would have been remanded as there was no showing of a federal question. (App. F-2). Once a sustainable basis for removal was presented, a jury demand was promptly filed. The Fifth Circuit chose not to provide any discussion on this point, holding merely that the jury demand was not filed within ten days of removal. (App. A-7 – A-8).

Next, the Hogues presented authority from both the leading treatise on federal procedure and the Ninth Circuit that, where the defendant's answer is filed after the case is removed, the time to file the jury demand is governed by Fed. R. Civ. P. 38(b) and not 81(c). 9 Charles A. Wright & Arthur R. Miller, Federal Practice and Procedure §§ 2319-2320 (1971); *Tushner v. U.S. Dist. Court for Cent. Dist. of Cal.*, 829 F.2d 853 (9th Cir. 1987).[2] The Fifth Circuit avoided a discussion of this position by citing *Callejo v. Bancomer*, 764 F.2d 1101, 117 (sic) n. 20 (5th Cir. 1985) for the statement that "[a]n issue not raised in the district court will not be considered on appeal unless the issue can be resolved as a matter of law and unless failure

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[2] Although Justice Kennedy's opinion in *Tushner* does not squarely answer the question presented, the jury demand filed in that case would not have been timely if calculated from the date of removal, but was held by the Ninth Circuit to have been timely filed. Therefore, the Ninth Circuit had to have calculated the time in which to file the jury demand from the answer date.

to do so would result in grave injustice". (App. A-8). Yet, as the Hogues told the Fifth Circuit panel, whether their jury demand was timely was a legal issue, determined on undisputed facts. Moreover, the loss of a timely asserted fundamental constitutional right was certainly a grave injustice. And, arguing Rule 38 on appeal was quite different from joining the issue for the first time on appeal. The issue – whether the jury demand was timely – was undeniably raised in the trial court through the defendants' Motion to Strike Jury Demand. As indicated, the Fifth Circuit was unmoved. (App. A-8; App. B). As a result, this Court is left as the only defender of the Hogues' fundamental right to a trial by jury. Not only have the lower courts failed to give the Hogues every reasonable presumption against waiver, one is challenged to identify a single indulgence tilted in their direction.

This Court is the primary arbiter of the Federal Rules. The highest duties imposed on this Court are the administration of the federal courts and the protection of constitutional rights. This is a case of first impression on the preservation of the Seventh Amendment right to a jury. There are no cases deciding when a proper jury demand must be filed if the defendant answers after the case is removed. The Court should take this opportunity to resolve the conflict between Rule 38(b) and 81(c) and declare which rule should control and why, especially since a fundamental right hangs in the balance.

This case is also one of first impression on the question of what obligation, if any, does a removed party have to request a jury when the basis asserted for removal is faulty. Must a removed party anticipate whether or not a faulty removal can be cured at the peril of losing a

constitutional right? This is exactly the type of question this Court is compelled to answer.

The Hogues were confronted with an outrageous fact situation which should have been heard by a jury. The only reason this case was not heard by a jury is because the magistrate judge gave short shrift to the Federal Rules and the Seventh Amendment. As is indicated in this petition, the denial of the requested jury has resulted in a gross misapplication of state law; therefore, it is of primary importance that this Court grant certiorari in order to consider whether or not that denial was proper.

2. This Court Should Grant Certiorari Because of the Public Policy Interest in Health Insurance Benefits.

This country is in the midst of a national debate concerning the payment for the health care of its population. In this case we have a family that has played by the rules and done what the current system is supposed to reward them for doing. They bought private insurance. Unfortunately, they called upon their benefits to do the very thing one buys insurance to do and, as a result, they have been left uninsured, uninsurable, scared, and apprehensive at the prospects of what each day may bring should Mr. Hogue's Hodgkin's disease recur. Certainly, they could consume all their resources to pay for health care and then seek government assistance for whatever was left over. We all know that to be the most wasteful, ineffective, and expensive manner of treatment.

Instead, they appeal to the court system to redress their grievance. When one buys insurance, a benefit of the bargain is peace of mind that medical expenses will

not result in your impoverishment. The function of insurance is to spread the risk that an insured will incur claims over both the healthy and the ill, not to simply raise the premiums on those who need insurance the most until they are forced to lose their coverage. The very essence of insurance should prohibit a health insurance company from being able to unilaterally dictate when a policyholder remains insured and when they are cast adrift and uninsurable. It is entirely reasonable that, when insurance terminates, any expenses relating to a condition predating the termination remain the obligation of the insurer.

Most people would expect there to be current laws which would protect them from what has happened to the Hogues. Obviously, two lower courts have disagreed with them, yet these questions are so significant and of such a compelling public interest, that this Court, as the court of last resort, should give these issues due consideration. As will be proven, the lower courts have so clearly and substantially departed from Texas law that to refuse to grant this writ would do no more than perpetuate what is already a terrible atrocity. Furthermore, although this is a case that probably should have been resolved in the state court system, the outcome will undoubtedly be monitored by countless ERISA plan administrators. If this Petition is denied and the cancellation of the Hogues' insurance in this manner is permitted under state law, then the same practice will be adopted in ERISA situations and countless ERISA cases will begin percolating their way through the federal courts on essentially the same facts.

Millions of people, confident they are fulfilling their responsibility to their families, go to sleep each night secure that should some dreaded medical tragedy visit them, they will be protected by insurance. Health insurance is more than a mere medical annuity, a distinction embraced by this Court as recently as January 18, 1995, in *Nationsbank v. Variable Annuity Life Ins. Co.*, ___ U.S. ___, 115 S.Ct. 810, 811-812, 130 L.Ed.2d 740 (1995). If the premise from which this logic flows proves as faulty as it has for the Hogues, the consumers of health insurance are in for a very rude awakening. Even if the lower courts have correctly resolved this controversy, the pervasive effect of such a determination should be issued under the authority of this Court after a just consideration of the case on its merits.

3. This Court Should Grant Certiorari Because the Lower Courts Have Plainly Erred in Their Interpretation of Texas Law.

This Court has repeatedly pledged that it will not be bound by the lower courts' construction of state statutes where there is plain error. *Frisby v. Schultz*, 487 U.S. 474, 483, 108 S.Ct. 2495, 2501, 101 L.Ed.2d 420 (1988); *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 500 n. 9, 105 S.Ct. 2794, 2800 n. 9, 86 L.Ed.2d 394 (1985), *citing Palmer v. Hoffman*, 318 U.S. 109, 118, 63 S.Ct. 477, 482, 87 L.Ed. 645 (1943) ("plain error"); *The Tungus v. Skovgaard*, 358 U.S. 588, 596, 79 S.Ct. 503, 508, 3 L.Ed.2d 524 (1959) ("clearly wrong"); *United States v. Durham Lumber Co.*, 363 U.S. 522, 527, 80 S.Ct. 1282, 1285, 4 L.Ed.2d 1371 (1960) ("clearly erroneous"); and *Propper v. Clark*, 337 U.S. 472, 486-487, 69

S.Ct. 1333, 1340-1341, 93 L.Ed. 1480 (1949) ("unreasonable"). Recognizing that the function of this Petition is not to brief the case, including the state-law questions, on its merits, an attempt will be made in a conclusory fashion to demonstrate that the lower courts have misinterpreted Texas law in a number of areas. Petitioners once again assert that the primary purpose of seeking Supreme Court review is not so much for the evaluation of state-law questions, but to point out the gross misapplications of state law which have resulted from the wrongful denial of their right to a jury.

A. Duty of Good Faith and Fair Dealing

Both the magistrate judge and the Fifth Circuit refused to apply the duty of good faith and fair dealing to the termination of the Hogues' insurance policy by holding that pursuant to *Thrash v. State Farm Fire & Casualty Co.*, 992 F.2d 1354 (5th Cir. 1993) an insurer breaches that duty only when it lacks a reasonable basis for denying or delaying payment of a claim or when it knew or should have known that no such basis exists. Both lower courts rejected the Hogues' argument that the duty of good faith and fair dealing recognized in Texas emanates from the relationship between the insurance company and the policyholder and, therefore, applies to the entire course of dealing, particularly the policy's termination. The lower courts limited the duty to the evaluation and payment of claims. (App. A-7; App. D-22 – D-23). Subsequent to *Thrash*, but before the Fifth Circuit decided this case, the Texas Supreme Court held that "a failure to extend the duty of good faith and fair dealing to the cancellation of

an insurance policy would allow insurers to avoid bad faith liability by cancelling the entire policy rather than denying a single claim". *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278, 283 (Tex. 1994). Contrary to a situation where the lower courts have had to predict how the state courts would rule on an issue, the Texas Supreme Court has expressly provided the necessary guidance. The Fifth Circuit is absolutely bound to apply state law as determined by its highest court. *Erie R. Co. v. Tompkins*, 304 U.S. 64, 78, 58 S.Ct. 817, 822, 82 L.Ed. 1188 (1938). Where a Fifth Circuit panel has chosen to follow its own precedent, without discussion, in direct contravention to the determination of the Texas Supreme Court, the Hogues have no option but to appeal to the supervisory power of this Court and request that certiorari be granted. How is *Erie* to be enforced against a court of appeals unless this Court will grant certiorari? Surely, respect for the federal judiciary demands that it be required to apply state law as announced by the state's highest court.

B. Group v. Individual Insurance[3]

At all times material to this action, the Hogues purchased their insurance as individuals. That is to say that Mrs. Hogue personally went into an insurance agent's office and arranged for her family to be insured. None of

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[3] The significance of this issue is that the Fifth Circuit avoided discussing Tex. Ins. Code art. 3.70-3(B)(6) by holding the Hogue's policy to be group insurance. Art. 3.70-3(B)(6) would have required United Olympic to offer continued coverage to the Hogues.

the insurance at issue in this case was provided by either Mr. or Mrs. Hogue's employer and all premiums were paid directly by them. The Fifth Circuit also found that the Hogues had group insurance because their United Olympic booklet said so and because they had previously purchased insurance as a member of a consumer association pursuant to Tex. Ins. Code art. 3.51-6 § 1(a)(2). (App. H-4).

Subsection (a)(2) refers to policies issued to an association, but requires that such association have bylaws and a constitution, have been organized and in existence for at least two years, and have been organized for a good faith purpose other than the obtaining of insurance. No evidence was presented either at trial or to the Fifth Circuit that any, much less all, of these conditions had been met; therefore, for the Fifth Circuit to conclude that the Hogues were insured by GIC as members of a group pursuant to art. 3.51-6 § 1(a)(2) was without any basis whatsoever and constituted plain error. Furthermore, none of the other subsections are even remotely applicable. Subsection (a)(1) provides for employer-provided insurance, (a)(3) relates to insurance provided by labor unions or employers in related industries, (a)(4) is for persons insured under group life policies, and (a)(5) provides for insurance to persons who had formerly been insured as employees or members under a previous subsection.

In *Brown v. Granatelli*, 897 F.2d 1351, 1355 (5th Cir.), *cert. denied*, 498 U.S. 848, 111 S.Ct. 137, 112 L.Ed.2d 104 (1990), the Fifth Circuit stated that an "individual policy is one purchased by an individual for himself and his family", and that a "group" policy is one purchased by "an employer or other qualified organization for a group

of individuals and their families". In *Brown*, the Fifth Circuit further pledged to look beyond form to the substance of the relationship between the plan, the participants, and the insurance carrier. The Fifth Circuit has failed to honor this promise and this Court's power of supervision should be exercised to remedy an erroneous interpretation of the Texas Insurance Code.

C. Determination of the "Class" of Insureds to which the Hogues Belonged

Tex. Ins. Code art. 21.21 § 4(7)(b) prohibits discrimination among individuals of the same class. The Fifth Circuit, like the trial court, followed *Reeves v. New York Life Ins. Co.*, 421 S.W.2d 686, 688 (Tex. Civ. App. – Dallas 1967, writ ref'd n.r.e.) for the definition of "class". Although the Fifth Circuit did not elaborate, the trial court specifically held that Hogues' "class" was "composed of insureds who presented a risk similar to that of a person in remission from Hodgkin's disease and suffering rheumatoid arthritis and prostate problems". (App. C-11). This ignores the various letters sent by the defendants factually evidencing that United Olympic "classified" its policyholders based on age, sex, geographic location, and benefit package. (*See* App. M-1).

D. The Defendants Made Actionable Misrepresentations to the Hogues

The lower courts denied the Hogues' misrepresentation claims on the ground that the false or misleading statements were "just puffing" and, as such, were not

actionable pursuant to the Texas Deceptive Trade Practices – Consumer Protection Act ("the DTPA"). (App. A-5; App. C-20 – C-21). Tex. Bus. & Com. Code § 17.41 *et seq.* The Fifth Circuit's cited to its previous opinion in *Presidio Enterprises v. Warner Brothers*, 784 F.2d 674, 686 (5th Cir. 1986). While reserving an exhaustive argument as to why *Presidio* is not controlling for the presentation of this case on its merits, suffice to say that this Court should grant certiorari because the Texas Supreme Court has consistently refused to recognize any common law defenses to the DTPA, despite numerous opportunities to do so. *See Ojeda de Toca v. Wise*, 748 S.W.2d 449, 451 (Tex. 1988) (recognizes defenses to a DTPA action are set out in that act); *Alvardo v. Bolton*, 749 S.W.2d 47, 48 (Tex. 1988) (merger doctrine may not be used to defeat a DTPA claim); *Kennemore v. Bennett*, 755 S.W.2d 89, 91 (Tex. 1988) (waiver and estoppel not permitted as a defense to DTPA); *Haney v. Purcell Company, Inc.*, 770 S.W.2d 566, 567 (Tex. 1989) (abandonment of property as a cemetery was not a defense to DTPA suit against seller for failure to disclose); *William M. Mercer, Inc. v. Woods*, 717 S.W.2d 391, 401 (Tex. App. – Texarkana 1986), *aff'd in part, rev'd on other grounds*, 769 S.W.2d 515 (Tex. 1988) (common law defenses may not be used to defeat DTPA claims); *Weitzel v. Barnes*, 691 S.W.2d 598, 600 (Tex. 1985) (court of appeals erred in requiring proof of reliance on a misrepresentation); *Chastain v. Koonce*, 700 S.W.2d 579, 583 (Tex. 1985) (refusing to imply requirement of intent, knowledge, or conscious indifference); *Kennedy v. Sale*, 689 S.W.2d 890, 892 (Tex. 1985) (refusing to imply privity requirement); *Hurst v. Sears, Roebuck & Co.*, 647 S.W.2d 249, 251 (Tex. 1983) (refusing to imply impossibility defense.). Although

the trial court relied upon the Dallas' Court of Appeals holding in *Autohaus, Inc. v. Aguilar*, 794 S.W.2d 459 (Tex. App. – Dallas 1990, writ denied) as authority for the "puffing defense" (App. C-21), both it and the Fifth Circuit have ignored the fact that in denying the requested writ of error in that case[4], the Texas Supreme Court issued a per curiam opinion stating that its denial of the application was "not to be construed as approving or disapproving the analysis of the court of appeals" on the puffing issue. *Aguilar v. Autohaus, Inc.*, 800 S.W.2d 853, 854 (Tex. 1991) (per curiam).

Moreover, the statements at issue are actionable regardless of the puffing defense. The Fifth Circuit's holding in *Presidio* is founded on the Texas Supreme Court case of *Pennington v. Singleton*, 606 S.W.2d 682 (Tex. 1980). In *Pennington*, puffing was not allowed as a defense, false *general* descriptions were stated to be prohibited by the DTPA, and representations that the item was in "excellent" or "perfect" condition were found to be actionable. At best, the Fifth Circuit's continued promotion of *Presidio* as an accurate portrayal of Texas law is clearly erroneous and should call for this Court to exercise its power of supervision.

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[4] A "denial" of a writ of error means that the Texas Supreme was not satisfied that the court of appeals had correctly declared the law.

CONCLUSION

The Fifth Circuit erred in affirming the trial court. The denial of the Hogues' Seventh Amendment right to a jury was fundamental. Exacerbated by that jury denial were holdings in direct contravention of Texas law. Finally, the outcome of this case is of such a compelling interest that its resolution without review by this Court would be a grave injustice.

WHEREFORE, Petitioners, Michael and Carol Hogue, respectfully pray that this Court grant them a Writ of Certiorari, reverse the judgments of the Court of Appeals for the Fifth Circuit and the trial court, and remand this case for a jury trial with instructions as to the correct interpretation of Texas law.

Respectfully submitted,

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APPENDIX A

Michael HOGUE and Carol Hogue,
Plaintiffs-Appellants,

v.

UNITED OLYMPIC LIFE INSURANCE COMPANY, Delaware Administrators, and Consultants & Administrators, Inc.,
Defendants-Appellees.

No. 93-5435.

United States Court of Appeals,
Fifth Circuit.

Dec. 7, 1994.

Insureds brought suit against health insurer after their premiums were increased by 413%. Following bench trial before the United States District Court for the Eastern District of Texas, Judith K. Guthrie, United States Magistrate Judge, judgment was entered for insurer dismissing insureds' claims. Insureds appealed. The Court of Appeals, Stewart, Circuit Judge, held that: (1) under Texas law, health insurer did not discriminate against insureds when it split its policyholders into two groups and put them in policy group with other insureds whose paid/loss ratios were more than 80%; (2) insurer's actions were not unconscionable under Texas Consumer Protection Act; (3) insurer's statements in letter soliciting business constituted mere puffery rather than actionable misrepresentation; (4) insurer had no continuing responsibility for medical payments under lapsed group insurance policy; and (5) insurer did not breach duty of good faith.

Affirmed.

Appeal from the United States District Court for the Eastern District of Texas.

Before GARWOOD, JOLLY and STEWART, Circuit Judges.

STEWART, Circuit Judge:

Michael and Carol Hogue appeal the judgment of the district court dismissing their claims resulting from the termination of their insurance policy with United Olympic Insurance Company. For the following reasons, the judgment of the district court is affirmed.

BACKGROUND

Michael and Carol Hogue were insured by United Olympic Life Insurance Company ("United Olympic"). Their policy was part of a large group of policies in what was called the "Med-Preference" or "Med-Choice" Trust ("the Old Trust"). On July 1, 1990, the Hogues' health insurance premiums were increased by 18 percent. At that time the Hogues' policy offered the following benefits: United Olympic would pay 80 percent (co-payment) of the first $5,000 in claims after the deductible, then pay 100 percent of any claims beyond that amount. By letter dated November 29, 1990, the Hogues were notified that their benefits were being reduced to a 60 percent co-payment and $10,000 stop-loss. That change was to take effect on February 1, 1991. The premiums remained the same. But another letter dated January 22, 1991, notified the Hogues that their premiums would increase on March 1, 1991, by 413 percent. However, one month before the increase went into effect the Hogues stopped paying their

premiums; the policy lapsed on January 31, 1991, for nonpayment of premiums.

It was later learned that United Olympic had decided to split the group of policyholders into two groups. Those who had filed claims equaling less than 80 percent of their premiums paid were moved into a new trust. Those whose paid/loss ratios were more than 80 percent, which included the Hogues, remained in the old trust. Everyone in the old trust was subjected to the large increase in premiums.

After their insurance policy was cancelled, the Hogues sued United Olympic for discrimination, misrepresentation, unconscionable acts, breach of contract, and for a declaratory judgment that United Olympic was responsible for future medical costs. A request for a jury trial was made, but was denied as untimely. A bench trial was held and the trial court found for United Olympic.

DISCUSSION

Discrimination Claim

The Hogues contend that the district court erred in not finding that United Olympic had discriminated against them by leaving them in the Old Trust when it was split up. Under Texas law, it is unlawful to make or permit:

> any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premiums, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or

> conditions of such contract, or in any other manner whatsoever.

Tex.Ins.Code art. 21.21 § 4(7)(b). The Hogues argue that, by placing them in a trust based on profitability, they were unlawfully discriminated against. We disagree.

In order to prevail on a claim of insurance discrimination, the Hogues had to show that other individuals of the same class and hazards as them were charged lesser premiums or were given greater benefits. *Reeves v. New York Life Insurance Co.*, 421 S.W.2d 686, 688 (Tex.Civ.App.1967). No evidence was offered about other insureds who might have been charged a greater rate or received a greater benefit. The Hogues have thus failed to meet their burden of proof.

Unconscionability Claim

The Hogues contend that categorizing them into the Old Trust was unconscionable and thus violated section 17.45(5) of the Texas Consumer Protection Act. Under Tex.Bus. & Com.Code § 17.45(5), an unconscionable act is one which "takes advantage of the lack of knowledge, ability, experience, or capacity of a person to a grossly unfair degree" or "results in a gross disparity between the value received and consideration paid in a transaction involving the transfer of consideration."

After examining the record, we see no evidence that United Olympic performed any unconscionable acts. At trial, United Olympic's actuarial expert testified that the trust was split because the particular group of insurance policies was losing money. He stated that this action was one in a series of actions that United Olympic undertook

in order to preserve the viability of the insurance policies in the trust. The uncontroverted evidence thus shows that United Olympic operated based on actuarial considerations to shore up losses in an unprofitable insurance group. There is no evidence that United Olympic tried to take advantage of the Hogues as contemplated by the statute. There is also no evidence that United Olympic took more in consideration than the Hogues paid in consideration. We therefore find the Hogues have failed to prove that United Olympic's actions were unconscionable.

Misrepresentation Claim

The Hogues contend that United Olympic made actionable misrepresentations in letters it sent to them to persuade them to take out the insurance policy. A party makes an actionable misrepresentation under Texas law by "[m]aking, issuing, circulating, or causing to be made, issued or circulated any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby . . . or making any misleading representation or any misrepresentations as to the financial strength of the insurer." Texas.Ins.Code art. 21.21 § 4(1). Puffing i.e. loose general statements made by the sellers is not actionable as a misrepresentation. *Presidio Enterprises v. Warner Brothers*, 784 F.2d 674, 686 (5th Cir.1986). The district court found that the letters were just puffing and after reading the letters, we agree.

The letters make statements that United Olympic is a good insurance company that is able and willing to

undertake the commitment of the Hogues insurance. There are no promises or any other statements in the letters that would indicate that United Olympic would not raise their premiums, cancel their policy or do anything else to that effect. We find that the statements in the letters were just "puffery" and are not actionable under Tex.Ins.Code art. 21.21.

Continuing Responsibility for Medical Payments

The Hogues contend that United Olympic is still responsible for any claim that arose while the policy was still in force. They rely on the last sentence of Tex.Ins.Code art. 3.70-3(B)(6) which states that: "Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation." The Hogues contend that this section of the insurance code restricts United Olympic from cancelling the insurance policy and thus ceasing to pay benefits.

However Tex.Ins.Code art. 3.70-8 states that "[n]othing in this act shall apply to or affect . . . (3) any blanket or group insurance policy." A group insurance policy is a policy issued by an employer, an association, or other qualified groups. Tex.Ins.Code art. 3.51-6 § 1(a)(1-5). Our review of the evidence reveals that the Hogues initially bought their insurance coverage by becoming a member of a consumer association which entitled them to be issued a group policy under the association's banner. *See* Tex.Ins.Code art. 3.51-6 § 1(a)(2). United Olympic became the Hogues' insurer when it assumed the responsibility for the policies after two previous insurance associations failed. After United Olympic

became insurer, the Hogues' policy and the other policies continued to be administered as group insurance policies. Their policy book stated it was a group insurance policy and they were given a group rate. We find that the Hogues' policy was a group policy and thus Tex.Ins.Code art. 3.70-3(B)(6) is inapplicable to this case.

Breach of the Duty of Good Faith

The Hogues contend that United Olympic breached its duty of good faith and fair dealing by refusing to pay for medical bills after the policy had lapsed and by undertaking a subterfuge to render them uninsurable. In *Thrash v. State Farm Fire & Casualty Co.*, 992 F.2d 1354 (5th Cir.1993), this court stated that an insurer breaches its duty of good faith and fair dealing "*only* when it lacks a reasonable basis for denying or delaying payment of the claim [(sic) or] when it knew or should have known no such basis exists." *Id.* at 1358 (emphasis added). The evidence at trial showed that United Olympic paid all claims as they became due. These claims amounted to approximately $26,500 while the Hogues only paid $3,658.42 in premiums. Thus, United Olympic has fulfilled its duty of good faith and fair dealing by paying all claims due while the policy was in effect. We find this contention to be without merit.

Jury Demand

The Hogues contend that the district court erred in finding that they had not made a timely jury demand. The district court denied the Hogues jury request holding that the jury demand had not been filed within ten days

of removal as required by Fed.R.Civ.P. 81(c). The Hogues argue for the first time on appeal that pursuant to Fed.R.Civ.P. 38(b), they only had to file a jury demand within ten days after United Olympic filed its answer, which they did given the time allowances for filing by mail. An issue not raised in the district court will not be considered on appeal unless the issue can be resolved as a matter of law and unless failure to do so would result in grave injustice. *Callejo v. Bancomer,* 764 F.2d 1101, 117 n. 20 (5th Cir.1985). Having reviewed the entire record and the applicable law, we find no error in the district court's denial of the Hogues' jury demand.

CONCLUSION

For the foregoing reasons, the judgment of the district court is AFFIRMED.

APPENDIX B

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

No. 93-5435

MICHAEL HOGUE and
CAROL HOGUE,

Plaintiffs-Appellants,

versus

UNITED OLYMPIC LIFE
INSURANCE CO., ET AL.,

Defendants-Appellees.

Appeal from the United States District Court for the
Eastern District of Texas

(Filed Jan. 9, 1995)

ON PETITION FOR REHEARING AND SUGGESTION
FOR REHEARING EN BANC

(Opinion ___), (5 Cir., ___), (___) F.3d (___)
(January 9, 1995)

Before GARWOOD, JOLLY and STEWART, Circuit Judges.

PER CURIAM:

(X) The Petition for Rehearing is DENIED and no member of this panel nor Judge in regular active service on the Court having requested that the Court be polled on

rehearing en banc, (FRAP and Local Rule 35) the Suggestion for Rehearing En Banc is also DENIED.

( ) The Petition for Rehearing is DENIED and the Court having been polled at the request of one of the members of the Court and a majority of the Judges who are in regular active service not having voted in favor, (FRAP and Local Rule 35) the Suggestion for Rehearing En Banc is also DENIED.

( ) A members of the Court in active service having requested a poll on the reconsideration of this cause en banc, and a majority of the judges in active service not having voted in favor, rehearing en banc is DENIED.

ENTERED FOR THE COURT:

/s/ Carl E. Stewart
United States Circuit Judge

CLERK'S NOTE:
SEE FRAP AND LOCAL RULES 41 FOR STAY OF THE MANDATE.

APPENDIX C

IN THE UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF TEXAS

TYLER DIVISION

MICHAEL HOGUE AND CAROL HOGUE	§	
V.	§	CIVIL ACTION NO. 6:92cv595
UNITED OLYMPIC LIFE INSURANCE COMPANY, DELAWARE ADMINISTRATORS, AND CONSULTANTS AND ADMINISTRATORS, INC.	§	

MEMORANDUM OPINION

Plaintiffs Michael Hogue and Carol Hogue filed this civil action on September 18, 1992, alleging that Defendants United Olympic Life Insurance Company ("United Olympic") and Delaware Administrators, formerly Consultants & Administrators, Inc. ("C&A") engaged in unfair discrimination under the Texas Insurance Code, unconscionable conduct under the Texas Deceptive Trade Practices Act, misrepresentations regarding Plaintiffs' insurance policy, constructive cancellation, and a breach of the duty of good faith and fair dealing.

The case was tried to the Court on June 15 and 16, 1993. For the reasons stated below, judgment will issue that the Plaintiffs take nothing by their suit.

I. Findings of Fact

In a trial before the bench, the Court must find the facts specially and make conclusions of law. Rule 52(a), Fed. R. Civ. P. This rule recognizes and rests upon the unique opportunity afforded the trial judge to evaluate the credibility of witnesses and weigh the evidence. *Inwood Laboratories, Inc. v. Ives Laboratories*, 456 U.S. 844, 855, 102 S.Ct. 2182, 72 L.Ed.2d 606 (1982). Therefore, pursuant to Rule 52, I find from a preponderance of the credible evidence that the following facts are true.

Plaintiff Michael Hogue is employed by Smith Tank and Equipment Company ("Smith Tank") of Tyler, Texas, and has been continuously employed by that company since 1962. At present he earns approximately $50,000 per year as the Vice President of Sales Engineering. For most of the time between 1962 and 1988, Smith Tank provided group health insurance benefits for its employees and their dependents, including the Plaintiffs. Mr. Hogue has suffered prostate problems for most of his life, and in 1982 he was diagnosed with rheumatoid arthritis. In 1988, Smith Tank ceased offering group health insurance benefits for its employees.

In April of 1989, Plaintiff obtained group insurance from G.I.C. Insurance Company through its administrator, Risk Funding Alternatives ("RFA") and a Tyler, Texas insurance agency. Plaintiff obtained the policy as a member of a policyholder called "World Wide Consumer Association." A few months later, G.I.C. went out of business and Plaintiffs' group policy was assumed by George Washington Life Insurance Company ("George Washington"). George Washington was also administered

by RFA. On September 21, 1989, while still covered by the George Washington policy, Mr. Hogue was diagnosed with Stage IV Hodgkins disease.

By letter dated September 29, 1989, George Washington and RFA notified all George Washington insureds, including Plaintiffs, that George Washington would no longer provide insurance coverage after October 31, 1989. RFA also notified its customers that a new " 'A+ Superior' rated" carrier would assume the George Washington policies on November 1, 1989, but that accidents or illnesses occurring before November 1, 1989, would be the responsibility of George Washington. An October 31, 1989, letter from RFA to "all insureds" stated that its affiliation with United Olympic would begin on November 1, 1989.

On October 31, 1989, Plaintiffs' coverage was canceled by George Washington. Plaintiffs paid their first premium for their new policy with a check dated November 2, 1989, and payable to Risk Funding Alternatives in the amount of $225. Plaintiffs received an application for insurance with Defendant United Olympic Life Insurance Company ("United Olympic") sometime after November 28, 1989, as an attachment to a letter from their local agent explaining that the application must be returned to RFA by December 1, 1989, to insure continued converage [sic]. Mrs. Hogue back-dated her husband's signature to October 31, 1989, and requested that the policy have an effective date of November 1, 1989. The application, entitled "Risk Funding Alternatives Participating Employer Application Employer Agreement," was signed, completed, and delivered to RFA after November 28, 1989, and on or before December 1, 1989. The Plaintiffs then

were insured as an employer group, effective November 1, 1989, under a policy issued by United Olympic to the "Med-Preference" or "Med-Choice" Trust ("the Old Trust"). The Old Trust was established for small employers, ranging from two to fifty employees, that would apply for participation in the Old Trust and, if accepted, would obtain group insurance coverage for their eligible employees under the Old Trust's policy. Approximately 4,500 employer groups participated in the trust. The application, signed by Mr. Hogue, states on page two that "the applicant understands that it is establishing its plan of insurance as an employer . . . ," and contained language relating to the Employee Retirement Income Security Act (ERISA). It also states that "[t]he agent has no authority to bind coverage under the group policy."

Sometime [sic] after November 1, 1989, Plaintiffs received a certificate booklet for their policy. The first page of the booklet states in part, under the heading of "Certificate of Group Insurance":

> This individual Certificate booklet is issued merely as evidence of insurance, provided under the Group Policy . . . THE BENEFITS DESCRIBED IN THIS CERTIFICATE ARE SUBJECT TO ALL THE PROVISIONS, TERMS AND CONDITIONS OF THE GROUP POLICY. THE GROUP POLICY, ALONE, CONSTITUTES THE ENTIRE CONTRACT UNDER WHICH RIGHTS AND BENEFITS ARE PROVIDED. The Group Policy may be amended, changed, canceled, or discontinued in accordance with the provisions thereof, without consent of the Insured Person or the Participating Employer(s).

Defendant C&A was the managing third-party administrator of the policy from November 1, 1989, to January 13, 1992. C&A was employed by United Olympic to manage operations such as claims processing, billing, and collections, because United Olympic was ill-equipped to handle such a large administrative task. RFA was a sub-administrator employed to assist C&A in its operations and to market the policy on C&A and United Olympic's behalf from February 1, 1990, to September 1991. Defendant Delaware Administrators replaced C&A as third-party administrator from January 13, 1992, to March 31, 1992.

On July 1, 1990, Plaintiffs' health premium was increased by 18% from $192 to $224.56 per month. United Olympic applied the 18% increase to the class of groups whose claims-loss ratio was less than 80% as of April 1990. Groups with a claims-loss ratio greater than 80% had their premiums increased to 150% over the "new case rate." At that time the Plaintiffs' policy offered the following benefits: after the deductible, United Olympic would pay 80% (co-payment) of the first $5,000 in claims (stop-loss) after the deductible, then 100% of any claims beyond that amount. By letter dated November 29, 1990, Plaintiffs were notified that their benefits were being reduced to a 60% co-payment and $10,000 stop-loss. That change was to take effect on February 1, 1991. The premium remained the same. But another letter dated January 22, 1991, notified Plaintiffs that their premiums would increase on March 1, 1991, by 413%.[1] However, one

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[1] The letter from RFA, the sub-administrator, was in error. United Olympic had ordered RFA to increase premiums in the

month before the increase went into effect Plaintiffs stopped paying their premium; the policy lapsed on January 31, 1991, for nonpayment of the $265.81 February premium.

All of these premium increases in 1990 and 1991 were explained by Defendant thusly:

In mid-1990 United Olympic realized that the Old Trust was losing money and made efforts to rehabilitate it. United Olympic raised rates, but this was unsuccessful because many of the groups with few claims left to find cheaper insurance elsewhere. Twenty-two million dollars in yearly premiums had been canceled either by the company or the insureds, and the financial performance of the Old Trust was much worse than had been expected. United Olympic feared the development of an "assessment spiral" in which rates would be raised, good customers would leave, rates would be raised again, more good customers would leave, etc.

To remain profitable, the Old Trust had to maintain a maximum 60-65% claims-loss ratio overall. When it became apparent that the Old Trust was not going to be profitable, United Olympic had three options: to raise

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Old Trust to 350% of the "new case rate." When properly calculated, the premiums would increase by 313% – not 413% as RFA's letter to Plaintiffs indicated. Plaintiffs' exhibit 40 contains a ledger with the names and the March 1991 percentage increases for "independents," including Michael Hogue, in both the new and old trusts.

rates further, terminate the Old Trust, or re-write existing business which passed underwriting[2] into a "New Trust."

United Olympic decided to try raising rates further as a means of restoring profitability. An August 13, 1990, letter from Noran Petroff, Renewal Underwriter for C&A, to Carl Owens of RFA directed RFA to implement a rate increase for groups in the Old Trust which were not affected by an earlier 150% rate increase and which did not have a rate guarantee; the Hogues belonged to this category and should have received the rate increase. However, RFA did not effectuate the increase. As a result of RFA's failure to implement the increase, C&A notified RFA by an October 31, 1990, letter that RFA would have to use C&A hardware and software in processing claims and premiums, and that a procedural and financial audit of RFA would commence.

On August 1, 1990, the "Med-Preference II" or "Med-Choice II" trust ("the New Trust") was created. Prior to that time, as discussed above, there were two classes of groups paying different rates: those with an 80% or above claims-loss ratio, and those with a less than 80% claims-loss ratio. United Olympic issued a group policy to the New Trust. New business, including qualified existing employer groups from the Old Trust, was placed in the New Trust. Existing employer groups in the Old Trust were qualified if their claims-loss ratio was less than 80%.

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[2] Mr. James Knight, former Senior Vice President and Chief Actuary for United Olympic, explained that underwriting is a process of examining "cases," or insureds, to determine whether they meet or exceed eligibility criteria. If the case meets or exceeds the criteria, it "passes."

As a result, higher risk groups were left in the Old Trust. If the New Trust had been established in April of 1990 rather than August of 1990, the Plaintiffs would have been eligible for placement in that trust because, at the time, their claims-loss ratio was less than 80%. Similarly, if Plaintiffs' claims-loss ratio had been less than 80% after the New Trust was created, they could have applied for placement. However, based on the fact that Plaintiffs' claims-loss ratio was above 80% when the New Trust was created, and remained above 80% thereafter, they were not eligible to apply.

The class of employer groups that remained in the Old Trust represented a greater actuarial risk than the class of groups that qualified for placement in the New Trust. However, United Olympic made its decisions regarding rates, benefits, and groups eligible for the New Trust based on the characteristics of employer groups, not individuals within those employer groups. The "Hogue group" remained in the Old Trust because it did not meet the underwriting criteria of the New Trust.

None of Defendant's efforts to save its health insurance business worked. By letter dated January 15, 1992, United Olympic notified all employer groups in both trusts that their insurance would terminate at midnight on March 31, 1992; and both group policies were terminated on that date. United Olympic merged with United Services Life Insurance Company in October of 1992. United Services Life does not offer health insurance.

Mr. James Knight, F.S.A., testified to most of the facts noted above. Other witnesses include Plaintiffs Michael and Carol Hogue, Dr. Robert Voogt, Ph.D., Dr. Arielle

Lee, M.D., Attorney Richard Hughes Davis, and Attorney J. Bennett White.

II. Conclusions of Law

Jurisdiction in this case is based on diversity of citizenship under 28 U.S.C. §1332. Plaintiffs Michael and Carol Hogue reside in Smith County, Texas. United Olympic is a Washington corporation, with its principal place of business in Bellevue, Washington. Delaware Administrators is an Ohio corporation with its principal place of business in Delaware, Ohio. The amount in controversy exceeds $50,000. Therefore, complete diversity of citizenship exists between the parties and this Court has original jurisdiction pursuant to 28 U.S.C. §1332.

Plaintiffs allege that Defendants engaged in unfair discrimination under the Texas Insurance Code, unconscionable conduct under the Texas Deceptive Trade Practices Act, misrepresentations regarding Plaintiffs' insurance policy, constructive cancellation, and a breach of the duty of good faith and fair dealing. The Court will address each issue *seriatim*.

A. Unfair Discrimination

To successfully assert a claim of unfair discrimination under TEX. INS. CODE ANN. art. 21.21 §4(7) (Vernon Supp. 1993), Plaintiffs must establish that Defendants discriminated against Mr. Hogue "by making or permitting unfair discrimination between individuals in the same class and of essentially the same hazard" as Mr. Hogue "in the

amount of premium, policy fees, or rates charged. . . . "[3] However, that clause is qualified by clause 8(b), relating to group insurance policies:

> Nothing in clause 7 . . . shall be construed as including within the definition of discrimination . . . any of the following practices:
>
> > (i) . . . (iii) readjustment of the rate of premium for a group insurance policy based on the loss or expense experienced thereunder, at the end of the first or any subsequent policy year of insurance thereunder, which may be made retroactive only for such policy year.

Plaintiffs urge that art. 21.21 §4(8)(b) (iii) does not apply because Plaintiffs did not hold a group policy, and that even if the policy was a group policy the "readjustments" did not occur at the end of a policy year. Plaintiffs also note that §4(8)(b) (iii), unlike §4(7)(b), is silent on the issue of benefits reduction. Conversely, Defendants argue that §4(7)(b) should not be applied, without limitation, to the Hogues' group insurance policy. The premiums and level of benefits available to Plaintiffs, Defendants argue,

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[3] The Insurance Code defines "unfair discrimination" as follows:

> (7) Unfair discrimination. (a) . . . (b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever; . . .

TEX. INS. CODE ANN. art 21.21 §4(7) (Vernon Supp. 1993).

were based on experiences of the groups insured under the policy, not Mr. Hogue's individual characteristics. Therefore, Defendants urge, Plaintiffs should be required to establish that a participating group under the policy which represented the same hazard and risk as the group to which Plaintiffs belonged received greater benefits for a lesser premium.

Plaintiffs contend that the Defendants unfairly discriminated against them by classifying them based merely on their claims-loss ratio and not for reasons related to their health. Plaintiffs argue that United Olympic should have canceled the original trust, and then formed two new trusts. Defendants respond that, based on sound actuarial principles, groups with a greater than 80% claims-loss ratio represent a higher risk. A "class," Defendants argue, is composed of groups with the same risk, not every individual insured by the company under a particular group policy. Moreover, Defendants point to the fact that United Olympic paid every claim that was due while Plaintiffs were insured, and insured the Plaintiffs notwithstanding Mr. Hogue's Hodgkins disease, rheumatoid arthritis, and prostate condition.

Defendants quote a rule promulgated by the State Board of Insurance in support of the rate differential:

> The following are hereby identified as acts or practices in life and health insurance which constitutes unfair discrimination between individuals of the same class: refusing to insure, or refusing to continue to insure, or limiting the amount, extent or kind of coverage available to an individual, or charging a different rate for the same coverage solely because of a physical

> or mental impairment, except where the refusal, limitation, or rate differential is based on sound actuarial principles or is related to actual or reasonably anticipated experience.

Tex. Dep't of Insurance, 28 TEX. ADMIN. CODE §21.702 (West 1988) (Unfair Competition and Unfair Practices of Insurers, and Misrepresentation of Policies)[4].

The Court has found only one Texas case construing art. 21.21 §4(7)(b). In *Reeves v. New York Life Ins. Co.* the Dallas Court of Civil Appeals upheld an insurer's refusal to pay a claim for a herniated disk. 421 S.W.2d 686 (Tex.Civ.App. – Dallas 1967, writ ref'd n.r.e.). New York Life Insurance Company denied Reeves' claim based upon an exclusionary rider to the policy. Reeves claimed that the exclusion violated art. 21.21 §4(7)(b) because he paid the same premium as other insureds, but suffered reduced coverage. In construing clause 7(b), the court held that "individuals of the same class and of essentially the same hazard" were those who, like the insured, had a history of lower back and knee problems." Reeves did not

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[4] The purpose of the Administrative Code is explained in Tex. Dep't of Insurance, 28 TEX. ADMIN. CODE §21.1 (West 1988) (Unfair Competition and Unfair Practices of Insurers, and Misrepresentation of Policies):

> It is the purpose of these sections to further define and state the standards that are necessary to prohibit deceptive acts or deceptive practices by insurers and insurance agents and other persons in their conduct of the business of insurance or in connection therewith, whether done directly or indirectly, and irrespective of whether the person is acting as insurer, principal, agent, employer, or employee, or in any other capacity or connection with such insurer.

present evidence that other individuals in the same "class" were charged lower premiums. The court added:

> To increase the premium for taking the risk for such a cause is not a discrimination, but a reasonable difference. If a higher premium for an increased risk were made unlawful, a person whose health is thus impaired could get no insurance.

Id. at 688, *quoting Hilson v. Sun Life Assurance Co.*, 132 F.2d 989 (5th Cir. 1943).

Plaintiffs distinguish Reeves because the alleged discrimination in that case was based on a specific medical condition: a herniated disk. In this case the distinction was made based only on the claims-loss ratio for each employer group.

Whether Mr. Hogue had an individual or group policy, Plaintiffs did not meet their burden of proof to establish that other similarly-situated insureds received greater benefits for lesser premiums under §4(7)(b). Plaintiffs fault Defendants for sorting groups by claims-loss ratio instead of health-related criteria. Assuming, *arguendo*, that a claims-loss ratio is not health-related, and further assuming that the New Trust/Old Trust dichotomy was illusory, Plaintiffs have not shown that insureds who enjoyed lower premiums and/or higher benefits were members of the same "class" as Mr. Hogue.

Plaintiffs argue that all of the insureds in the Old Trust were members of the same class, but *Reeves v. New York Life Ins. Co.* very clearly demonstrates that a "class," within the meaning of art. 21.21 §4(7)(b), is a group of persons who present similar levels of risk. No evidence

was presented that the insureds originally in the Old Trust represented the same or similar risk as Mr. Hogue. To the contrary, the only evidence offered on the subject was the testimony of Mr. James Knight, former Senior Vice President and Chief Actuary of United Olympic, who stated that the practice of basing rates and benefits on the claims-loss ratio is grounded in "sound actuarial principles." At best, discounting the testimony of Mr. Knight, Mr. Hogue's "class" was composed of insureds who presented a risk similar to that of a person in remission from Hodgkin's disease and suffering rheumatoid arthritis and prostate problems. Therefore, given the fact that no evidence was submitted to support the conclusion that members of the Plaintiffs' class had lower premiums or better benefits, Plaintiffs failed to prove by a preponderance of the credible evidence that Defendants unfairly discriminated against them.

B. Unconscionable Conduct

Plaintiffs' second cause of action is "unconscionable action or course of action" as defined in §17.45 of the Texas Deceptive Trade Practices Act:

> (5) "Unconscionable action or course of action" means an act or practice which, to a person's detriment:
>
> > (a) takes advantage of the lack of knowledge, ability, experience, or work capacity of a person to a grossly unfair degree; or
> >
> > (b) results in a gross disparity between the value received and the consideration paid,

> in a transaction involving a transfer of consideration.

TEX. BUS. & COM. CODE ANN. §17.45 (Vernon 1987). Plaintiffs' claim is actionable pursuant to §17.50(a)(3).

Plaintiffs aver that Defendants "took advantage of the Plaintiffs' inability to do anything about the 'New Trust/Old Trust' flimflam which resulted in Plaintiffs losing their insurance"; therefore, their claim is brought under the definition in §17.45(5)(a). Plaintiffs also note that "Defendants have admitted that they 'knowingly' engaged in the conduct which constitutes the unconscionable action or course of action."

Defendants counter that their actions cannot be viewed as unconscionable because: 1) United Olympic was losing money on the Group Policy throughout 1990; 2) had United Olympic not created the New Trust, the entire Group Policy would have been terminated for all groups; and 3) had the Group Policy been canceled, the Hogues would not even have had the option of maintaining their insurance.

Unconscionable action, by the terms of the statute, is an act or practice which either (a) is overbearing and evidences misuse of superior bargaining power or (b) results in a gross disparity between consideration paid and value received. *Dwight's Discount Vacuum Cleaner City, Inc. v. Scott Fetzer Co.*, 860 F.2d 646, 649 (5th Cir. 1988). In *Chastain v. Koonce*, the Texas Supreme Court refined the definition of "unconscionable action." 700 S.W.2d 579 (Tex.1985). The court, in considering whether there was evidence to support a jury finding of unconscionability, stated: "[s]ection 17.45(5) is intended to be an

objective standard." 700 S.W.2d at 583. As to subdivision (a) of section 17.45(5), the *Chastain* court said that "[t]aking advantage of a consumer's lack of knowledge to a grossly unfair degree thus requires a showing that the resulting unfairness was glaringly noticeable, flagrant, complete and unmitigated." *Id.* at 584. The Texas Supreme Court interpreted subdivision (b) to mean: "A slight disparity between the consideration paid and the value received is not unconscionable; a glaring and flagrant disparity is." *Id.* In determining whether an action is unconscionable, the Court must examine the entire transaction. *Id.* As stated above, Plaintiffs, claim is grounded in subsection (a).

Based on the record as a whole, the Court concludes that Defendants did not take advantage of Plaintiffs' alleged lack of knowledge to a grossly unfair degree.

United Olympic was losing money on the Old Trust in 1990. To remain profitable, the Old Trust had to maintain a claims-loss ratio of sixty to sixty-five percent. In its effort to rehabilitate the trust, United Olympic raised the premiums. This action was unsuccessful because the overall claims-loss ratio did not decline appreciably, and many of the lower risk insureds left to find cheaper insurance. United Olympic feared an "assessment spiral" which would ultimately lead to a termination of the trust, and it didn't want to terminate the trust; therefore it undertook a third option, which was to re-write existing business which qualified, along with new business, into the New Trust. Rates in the Old Trust were uniformly raised to 350% of the "new case rate" for groups with similar deductibles and benefits; for the Hogues this was a 313% increase over their current premium.

Throughout their association with United Olympic and the other Defendants, Plaintiffs' claims were paid notwithstanding the fact that they were linked exclusively to pre-existing conditions which were the responsibility of George Washington. Moreover, Defendants argue that even if Plaintiffs had passed underwriting and been placed in the New Trust until its termination in 1992, the premiums would have exceeded Plaintiffs' medical expenses.

The Court concludes that Plaintiffs failed to prove by a preponderance of the credible evidence that Defendants, to Plaintiffs' detriment, took advantage of their lack of knowledge, ability, experience, or work capacity to a grossly unfair degree.

C. Misrepresentation

Plaintiffs' claims of misrepresentation are based on communications from RFA, and are made pursuant to Articles 17.46(b)(5) of the Commerce Code and 21.21 § 4(1) of the Insurance Code. Section 17.45 states in relevant part:

> (b) Except as provided in Subsection (d) of this section, the term "false, misleading, or deceptive acts or practices" includes, but is not limited to, the following acts:
>
> > (1) . . . (5) representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities which they do not have or that a person has a sponsorship, approval, status, affiliation, or connection which he does not.

TEX. BUS. & COM. CODE ANN. § 17.45(b)(5) (Vernon 1987). Article 21.21 states in relevant part:

> Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:
>
> > (1) Misrepresentations and False Advertising of Policy Contracts. Making, issuing, circulating, or causing to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of any policy issued or to be issued or the benefits or advantages promised thereby . . . or making any misleading representation or any misrepresentation as to the financial condition of any insurer . . .

TEX. INS. CODE ANN. art. 21.21 § 4(1) (Vernon Supp. 1993).

Plaintiffs contend that RFA, an agent of Defendants, misrepresented material facts in several instances. First, Plaintiffs complain of a letter from RFA to Plaintiffs announcing its affiliation with United Olympic. Mrs. Hogue testified that she thought the letter meant that rates would not rise drastically. Plaintiffs also claim that the letter meant that insurance coverage provided by United Olympic would be continuous. Second, Plaintiffs complain of a letter from RFA to them explaining the reduction in benefits which did not mention the preferred-provider option ("PPO") whereby Plaintiffs could enjoy an 80% co-payment under certain conditions rather than the stated 60% co-payment. The last offending letter came from RFA to Plaintiffs informing them of a 413% rate increase which should have indicated a 313% increase.

Texas Courts are divided on the issue of whether an insurance company can be held vicariously liable for the representations of an agent such as RFA. A soliciting agent's authority is limited to reviewing and forwarding applications for insurance; such an agent has no authority to make a contract on behalf of the insurance company or to alter or waive the terms of the policy. TEX. INS. CODE ANN. art 21.04 (Vernon Supp. 1992). A recording agent is additionally authorized to write, sign and execute insurance policies and to bind the insurer. TEX. INS. CODE ANN. art. 21.14 § 2 (Vernon Supp. 1992). RFA was a soliciting agent for United Olympic.

Both solicitng [sic] and recording agents are "agents" of the insurance company, but there is ample authority for the proposition that soliciting agents cannot render their insurance companies liable for misrepresentations. *See Guthrie v. Republic Nat'l Life Ins. Co.*, 682 S.W.2d 634, 636 (Tex.App. – Houston [1st Dist.] 1984, writ ref'd n.r.e.); *American Nat'l Life Ins. Co. v. Montgomery*, 640 S.W.2d 346 (Tex.App. – Beaumont 1982, writ ref'd n.r.e.). However, other cases hold to the contrary. *See Celtic Life Ins. Co. v. Coats*, 831 S.W.2d 592, 596-97 (Tex.App. – Austin, 1992, writ pending); *Paramount Nat'l Life Ins. Co. v. Williams*, 772 S.W.2d 255 (Tex.App. – Houston [14th Dist.] 1988, writ denied). Notwithstanding this debate, the central theme of agency law still applies, and that is that in order to hold an insurer or other principal liable, an agent must have actual, implied, or apparent authority to make the representation. *Royal Globe Ins. Co. v. Bar Consultants, Inc.*, 577 S.W.2d 688 (Tex. 1979).

Having carefully considered the testimony of the witnesses and exhibits relevant to this issue, the Court concludes that RFA had either actual, implied, or apparent authority to make all of the foregoing statements. Though RFA was a soliciting agent, it was also an administrator; and as such it undertook to notify the Plaintiffs of their coverage, keep track of payments and claims, and notify Plaintiffs of changes in their coverage.

The first letter from RFA is dated September 29, 1989. It explains some of the details of changes necessitated by termination of the George Washington policy, and includes the following language:

> Our goal at Risk Funding Alternatives has one purpose . . . "To provide the finest service in the health insurance industry," and adding this "A+ Superior" rated company [United Olympic] to our network of coverage brings an extra level of security in these troubled times. . . . While many other insurance companies are being forced to announce unreasonable increases in premium[s] and reductions[s] [sic] in benefits, we hope that you can share in the excitement of a positive development of this magnitude. And before the end of the year, we will announce the development of new options to help control your health insurance cost, while maintaining quality service.

Although the DTPA does not specifically mention opinion or puffing[5], the Texas Supreme Court suggested

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[5] "Puffing" has been defined as an expression of opinion by a seller not made as a representation of fact. *Dowling v. NADW Marketing, Inc.*, 631 S.W.2d 726, 729 (Tex. 1982).

in *Pennington v. Singleton* that such a defense existed. 606 S.W.2d 682, 687 (Tex. 1980); *see also RRTM Resturant* [sic] *Corp. v. Keeping*, 766 S.W.2d 804, 807 (Tex.App. – Dallas 1988, writ denied). In that case, the Supreme Court held that the "general objective of § 17.46(b)(5) . . . is to ensure that descriptions of goods or services offered for sale are accurate. Misrepresentations, so long as they are of a material fact and are not merely 'puffing' or opinion, are nevertheless actionable. . . . " *Pennington v. Singleton*, 606 S.W.2d 682, 687 (Tex. 1980). Courts consider three variables in their determination of whether a statement is puffing and therefore not actionable: 1) the specificity of the statement; 2) comparative knowledge of buyer and seller; and 3) whether the representation pertains to a past or current event or condition, or to a future event or condition. *Autohaus, Inc. v. Aguilar*, 794 S.W.2d 459, 462 (Tex.App. – Dallas 1990, writ denied). An imprecise or vague representation constitutes a mere opinion. *Id.*

After carefully considering the language of the first communication, the Court concludes that the quoted portions constitute mere puffing and opinion, and do not, as Plaintiffs allege, constitute misrepresentations under either § 17.46(b)(5) of the Commerce Code or Article 21.21 § 4(1) of the Insurance Code. It is undisputed that no other communications regarding future rates were made by G.I.C., George Washington, United Olympic or its agents to the effect that rates would not rise.

The second alleged misrepresentation is found in a November 29, 1990, letter from RFA to Plaintiffs explaining the benefit reduction. Attached to that letter is a chart listing potential expenses and corresponding benefits. The chart reveals a 60% co-payment and $10,000 stop-loss

figure for each category of expense except "second surgical opinions . . . and hospice care," which lists a 100% benefit. No PPO option is indicated. Nor was the option mentioned in a memorandum from the October 24, 1990, meeting of Mr. Knight, C&A, and RFA representatives concerning benefit reductions. However, Mr. Knight testified that the 60% co-payment and $10,000 stop-loss reductions in benefits were intended to serve as a stimulus for use of the PPO, which retained the 80% co-payment and $5,000 stop-loss benefits. He admitted that a failure to notify groups of the PPO option would have been an error.

Plaintiff Carol Hogue testified that after she learned of the benefit reduction she decided to keep the United Olympic policy anyway because Mr. Hogue's medical background rendered other insurance unavailable. However, no evidence was offered that Plaintiffs abandoned medical treatment because of RFA's failure to notify them of the preferred-provider option or that they underwent medical treatment and received the 60% co-payment despite the fact that they could or would have taken advantage of the 80% PPO.

A third letter dated January 22, 1991, was sent from RFA to Plaintiffs explaining the 413% rate increase. Mr. Knight testified that the instructions from United Olympic to RFA were to raise rates in the Old Trust to 350% of the new case rate for each insured, with no insured to experience a decrease in premiums. For the Hogues, this actually amounted to a 313% increase over their past premium; or in other words, an increase to 413% of their past premium. The letter from RFA clearly states that "effective as of March 1, 1991, an increase of 413% will be

applied to your major medical premium." This error was not corrected by RFA. A March 1, 1991, premium statement from RFA notes $1151.99 due for Plaintiffs' March major medical coverage – a 413% increase over their past health premium – and $265.81 past due for February coverage.[6]

During the trial of this matter Plaintiff Carol Hogue testified that the Hogues could comfortably afford $300 per month for insurance, but in no case could they afford more than $800 per month. The monthly premium at the time of termination was $265; of that, $224.56 was attributable to major medical coverage. If RFA had applied the proper rate increase the Hogues still could not have afforded the insurance; a 313% increase of the $225 major medical premium results in a $929 health premium, and a $956 overall premium including the standard "membership fee," "dependent life," etc.

Article 21.21 § 4(1) of the Insurance Code and section 17.46(b)(5) of the Commerce Code are made actionable by article 21.21 § 16 and section 17.50(a) respectively. Both of the latter sections require actual damages in order for a plaintiff to prevail; a failure to prove actual damages

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[6] The premium and benefit changes are outlined in the following chart:

Begin Date	Co-payment	Stop-loss	Health Premium	Δ rate
11/89	80%	$ 5,000	$ 192	
7/90	80%	$10,000	$ 224.56	18%
2/91	60%	$10,000	$ 224.56	
3/91	60%	$10,000	$1,151.99	413%

invalidates the cause of action. *See* TEX. BUS. & COM. CODE ANN. § 17.50(a); TEX. INS. CODE ANN. art. 21.21 § 16(a). Plaintiffs failed to prove by a preponderance of the credible evidence that they suffered actual damages with respect to the alleged incidents of misrepresentation, therefore this cause of action must fail.

Plaintiffs also rely on this definition of misrepresentation in the Administrative Code:

> The term misrepresentation, or the prohibited conduct, act, or practice that constitutes misrepresentation by a person subject to the provisions of these sections, is defined as any one of the following acts or omissions:
>
> > (1) . . . (2) any omission to state a material fact necessary to make the statements made (considered in the light of the circumstances under which they are made) not misleading; . . .

Tex. Dep't of Insurance, 28 TEX. ADMIN. CODE § 21.4 (Unfair Competition and Unfair Practices of Insurers, and misrepresentation of Policies). This interpretation is advanced in support of Plaintiffs claim that Defendants misrepresented the "split" of the original trust into Old and New Trusts. As stated above, the New Trust was formed separately in August of 1990 for the purpose of taking in new business. Rehabilitative efforts were taken to make the Old Trust profitable and stem the loss.

C. Constructive Cancellation

In order to successfully assert that Defendants constructively canceled Plaintiffs' coverage, they have the

burden of showing that the rate increase or rate reduction was unreasonable and not necessary. *See Security Ben. Assoc. v. Hendrickson*, 94 S.W.2d 1257 (Tex.Civ.App. – El Paso 1936, no writ); *Sovereign Camp W.O.W. v. Cousins*, 26 S.W.2d 453 (Tex.Civ.App. – Austin 1930), *aff'd*, 120 Tex. 107, 35 S.W.2d 696 (1931). In the absence of a showing that the rate increase was not necessary, the rate increase is presumed reasonable. *Security Ben. Assoc. v. Hendrickson*, 94 S.W.2d 1257, 1258 (Tex.Civ.App. – El Paso 1936, no writ). The proper test is whether or not a necessity existed for the rates adopted; therefore, the amount of the rate change should not be considered exclusive of other considerations. *See Sovereign Camp W.O.W. v. Cousins*, 26 S.W.2d 453, 455 (Tex.Civ.App. – Austin 1930), *aff'd*, 120 Tex. 107, 35 S.W.2d 696 (1931).

Plaintiffs have not shown that the rate increases were unreasonable and unnecessary. To the contrary, the only evidence presented on the subject was from Mr. Knight, who set forth the options available to United Olympic directly before the rate increase and the general reasons for the increase. While Defendants did not present evidence explaining the precise method of arriving at the "350% of new case rate" increase for those in the Old Trust, it was not their burden to do so. Having carefully considered the testimony and other evidence presented at trial the Court concludes that Plaintiffs failed to prove by a preponderance of the credible evidence that Defendants constructively canceled their insurance coverage.

D. Breach of Duty of Good Faith and Fair Dealing

An insured states a cause of action for breach of the duty of good faith and fair dealing when the insured alleges there is no reasonable basis for denial of a claim or delay in payment, or a failure on the part of the insurer to determine whether there is any reasonable basis for the denial or delay. *Arnold v. National County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987). This duty arises from that special trust relationship between an insurer and its insured; it is the stop-gap which fills the void resulting from a disparity of bargaining power and exclusive control that the insurer has and exercises over claims processing. *State Farm Fire and Casualty Co. v. Simmons*, ___ S.W.2d ___, 1993 WL 274705, 5 (Tex.App. – Beaumont 1993, n.w.h.); *see Aranda v. Insurance Co. of North America*, 748 S.W.2d 210 (Tex. 1988). For an insurer to avoid liability for an alleged breach of its duty of good faith and fair dealing, it must have a reasonable basis for denying a claim made by its insured. *Id.* To establish the absence of such a reasonable basis for denial, a claimant must show that its insurer knew or should have known there was no reasonable basis for its denial. *Id.; see Vail v. Texas Farm Bureau Mut. Ins. Co.*, 754 S.W.2d 129 (Tex. 1988). An insurer is held to that degree of care and diligence which a man of ordinary prudence would exercise in the management of his own business. *Id, citing Arnold v. Nat'l County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987).

The only evidence of claims being denied in this case is that $1,694.60 in claims were denied after Plaintiffs' coverage lapsed for nonpayment is reasonable basis for denying a claim. Therefore, the Court concludes that

Plaintiffs failed to prove by a preponderance of the credible evidence that Defendants breached a duty of good faith and fair dealing with respect to the Plaintiffs.

E. Negligence, Gross Negligence, Breach of Contract

In their Second Amended Complaint, Plaintiffs raise three additional causes of action: negligence, gross negligence, and breach of contract. However, these causes of action were not mentioned during the trial of this matter including closing argument, in Plaintiffs' Trial Memorandum, in Plaintiffs' Proposed Findings of Fact and Conclusions of Law, or in Plaintiffs' Response to Defendants' Post Trial Brief. The Court, having exhaustively reviewed the record, concludes that Plaintiffs failed to prove by a preponderance of the credible evidence that Defendants were negligent, grossly negligent, or breached their contract with Plaintiffs.

III. Conclusion

Plaintiffs have failed to prove by a preponderance of the credible evidence that Defendants engaged in unfair discrimination under the Texas Insurance Code, unconscionable conduct under the Texas Deceptive Trade Practices Act, misrepresentation regarding Plaintiffs' insurance policy, or breached a duty of good faith and fair dealing.

Rising health insurance costs and a lack of insurance are unfortunate problems which many Americans face

every day. The Court is aware of and sensitive to Plaintiffs' dilemma. However, judicial intervention is limited to those circumstances in which a legal cause of action is asserted and proven by a preponderance of the evidence.

In light of the foregoing, it is

ORDERED that Plaintiffs take nothing and that this case be **DISMISSED** with prejudice. It is further

ORDERED that all motions not previously ruled on are hereby **DENIED.**

SIGNED this ___ day of August, 1993.

JUDITH K. GUTHRIE
UNITED STATES
MAGISTRATE JUDGE

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

MICHAEL HOGUE AND CAROL HOGUE	§	
	§	CIVIL ACTION
V.	§	NO. 6:92cv595
UNITED OLYMPIC LIFE INSURANCE COMPANY, DELAWARE ADMINISTRATORS, AND CONSULTANTS AND ADMINISTRATORS, INC.	§	(Filed Sep. 24, 1993)

MEMORANDUM ORDER

Came on for consideration Plaintiffs' Motions for Additional Findings pursuant to Rule 52(b), FED. R. CIV. P. (docket #56-1), and for New Trial Pursuant to Rule 59, FED. R. CIV. P. (docket #56-2) filed on August 26, 1993. Plaintiffs assert that the Court erred in its judgment entered in this case in the following respects: 1) the Court failed to make findings and conclusions with regard to Plaintiffs' request for a declaratory judgment on the issue of future medical coverage; 2) the Court made several factual findings that are against the great weight and preponderance of the evidence; 3) the Court erred in its findings and conclusions with regard to the issue of unconscionability; 4) the Court erred in its findings and conclusions with regard to the issue of discrimination; 5) the Court erred by failing to consider two of three letters from Defendant Risk Funding Alternatives, Inc. in determining whether Defendant misrepresented the subjects of

the letters; and 6) the Court erred in failing to properly define and analyze Defendants' duty of good faith and fair dealing. Plaintiff prays for amendment of the Court's Memorandum Opinion or, in the alternative, a new trial.

Defendants filed their Response to Plaintiffs' Motion for Additional Findings and for New Trial (docket #57) on September 8, 1993.

For the reasons set forth below, Plaintiffs' Motions for Additional Findings pursuant to Rule 52(b), FED. R. CIV. P. (docket #56-1), and for New Trial Pursuant to Rule 59, FED. R. CIV. P. (docket #56-2) filed on August 26, 1993, are denied.

Standards

A motion for additional findings is made pursuant to Rule 52(a) of the FED. R. CIV. P., which states in relevant part:

> . . . When findings of fact are made in actions tried by the court without a jury, the question of sufficiency of the evidence to support the findings may thereafter be raised whether or not the party raising the questions has made in the district court an objection to such findings, or has made a motion to amend them or a motion for summary judgment.

A motion for new trial is made pursuant to Rule 59 of the FED. R. CIV. P., which states in relevant part:

> A new trial may be granted to all or any of the parties and on all or part of the issues . . . in an action tried without a jury, for any of the reasons for which rehearings have heretofore been

granted in suits in equity in the courts of the United States. On a motion for a new trial in an action tried without a jury, the court may open the judgment if one has been entered, take additional testimony, amend findings of fact and conclusions of law or make new findings and conclusions, and direct the entry of a new judgment.

Discussion

Declaratory Judgment

Plaintiffs first contend that the Court erred in failing to make findings and conclusions with regard to Plaintiffs' request for a declaratory judgment on the issue of future medical coverage. Plaintiffs cite Texas law which provides that the cancellation of any health insurance policy "shall be without prejudice to any claim originating prior to the effective date of cancellation." TEX. INS. CODE ANN. art. 3.70-3(B)(6) (Vernon 1981). Plaintiffs contend that the quoted part of the statute fails to qualify itself with regard to which party, insurer or insured, canceled the policy. Plaintiffs further contend that the phrase "any claim originating prior" to cancellation includes claims arising before the start-date of the instant policy, or, in the alternative, that Defendant United Olympic Life Insurance Company's payment for claims related to illnesses originating prior to the policy resulted in a waiver of its right to exclude Plaintiff Michael Hogue's claims related to pre-existing illnesses.

Defendants respond that Plaintiffs' reliance on TEX. INS. CODE ANN. art. 3.70-3(B)(6) (Vernon 1981) is misplaced because their construction of that statute is faulty,

and that assuming Plaintiffs' construction of that statue [sic] is correct, it has no applicability in this case because Plaintiffs held a group policy. The cited provision is contained in subchapter G of the Insurance Code which states in Article 3.70-1(C) that "this act shall apply to and govern *individual accident and sickness insurance policies.*" TEX. INS. CODE ANN. art. 3.70-1(C) (Vernon Supp. 1993) (emphasis added).

Plaintiffs cite several cases in support of their construction. First, *Tusa v. Prudential Ins. Co. of America*, 825 F.2d 69 (5th Cir. 1987). In *Tusa* the Fifth Circuit was called on to determine whether a similar Louisiana statute[1] required Prudential to continue coverage of Tusa's child at the same benefit and premium as were in effect at the time of her birth.[2] Implicit in the decision is the fact that the child's claims "matured" when she was born, i.e., when her infirmities became apparent and her right to file claims vested. *See Tusa v. Prudential Ins. Co. of America*, 825 F.2d 69, n.3 (5th Cir. 1987). The second case cited by Plaintiffs, which is quoted in *Tusa*, is *Cataldie v. Louisiana Health Service & Indem. Co.*, 433 So.2d 367 (La.App. 1983),

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[1] The Louisiana statute permitted cancellation of a policy provided that the "cancellation shall be without prejudice to any claim originating prior thereto." La.R.S. 22:213, subd. (B)(7).

[2] Amanda Tusa was born with multiple congenital abnormalities, occasioning the need for a lifetime of extensive medical care. At the time of her birth, the Tusas had a $300 deductible, and the premium cost assigned to coverage for the children of the family was $67.24. When the action was filed, the Tusas were paying an annual premium of $4,954 and had a $5,000 deductible. *Tusa v. Prudential Ins. Co. of America*, 825 F.2d 69, 71 (5th Cir. 1987).

aff'd, 456 So.2d 1373 (1984). This case held that "[the court's] application of La.R.S. 22:213(B)(7) to the insurance contract does not make [the] policy uncancelable for any purpose other than to prevent prejudice to a claim which originated before cancellation . . . " *Id.* at 1377. In other words, the policy could be canceled unless prejudice would result. The *Tusa* court concluded that allowing Prudential to cancel coverage would surely result in "prejudice," and that the legality of such an action was conclusively foreclosed by the holding in *Cataldie. Tusa v. Prudential Ins. Co. of America*, 825 F.2d 69, 74 (5th Cir. 1987). This left only one issue for the court to decide: "whether Tusa is entitled to the premium level in effect when [the child's] physical infirmities came into being." *Id.* at 74. The court held that, with respect to the child, the Tusas were entitled to continued coverage, and premium and benefit levels equal to those applicable when the child was born. *Id.* The claims and coverages of other family members were not affected by the ruling because the child's was the only claim that "matured," or "originated," during the policy period.

The third case cited by Plaintiffs is *Nat'l Life & Accident Ins. Co. v. Dove*, 167 S.W.2d 257 (Tex.Civ.App. – Beaumont 1942), *aff'd*, 174 S.W.2d 245 (Tex. 1943). National Life issued a health policy to Dove which stated that cancellation would be "without prejudice to any claim originating prior thereto." Dove developed arteriosclerosis and myocarditis, and predicated his suit on the fact that National Life, after canceling the policy, refused to pay his claims related to the illnesses but filed after the policy's termination. Based on the fact that Dove was afflicted by a continuous illness, the court held that

"[t]he cancellation of the policy did not cancel [National Life's] obligation to pay benefits for this continuous illness, for the cancellation, by the terms of the policy, was without prejudice to [Dove's] claim for benefits based on his continuous illness which began prior to the cancellation." *Id.* at 260. Plaintiffs seize on the language in the last part of that sentence in support of their claim that the date the illness "originates" is immaterial, even if it was before coverage began. In *National Life,* Dove first became ill while covered under National Life's policy. *Id.* at 258-259.

Finally, in regard to their construction of TEX. INS. CODE ANN. art. 3.70-3(B)(6) (Vernon 1981), Plaintiffs cite *American Cas. Co. v. Horton,* 152 S.W.2d 395 (Tex.Civ.App. – Dallas 1941, writ dism'd) and *Drinkard v. Group Hospital Service, Inc.,* 366 S.W.2d 637 (Tex.Civ.App. – Dallas 1963, writ ref'd. n.r.e.). Though *American Casualty* did not involve policy language or a statute similar to Article 3.70-3(B)(6), the court did hold that the "policy being in full force and effect when plaintiff was accidentally injured resulting in total disability, his cause of action immediately arose, and he was entitled to recover the full amount of indemnity provided, irrespective of whether or not the policy was kept alive by the subsequent payment of premiums." *American Cas. Co. v. Horton,* 152 S.W.2d 395 (Tex.Civ.App. – Dallas 1941, writ dism'd). *Drinkard* similarly had nothing to do with Article 3.70-3(B)(6), but rested entirely on the language of the insurance policy in determining that the Drinkards were entitled to continued coverage for Mrs. Drinkard's

cancer.[3] However, it is notable that Mrs. Drinkard, as well as all of the other insureds in the cases cited above, contracted her illness during the term of the policy issued by the Defendant.

Plaintiffs contend that the quoted part of the statute fails to qualify itself with regard to which party, insurer or insured, canceled the policy. With regard to the cancellation of Plaintiffs' policy, the Court's Memorandum Opinion is very clear: the policy lapsed on January 31, 1991, for nonpayment of the $265.81 February premium before the end of the grace period. *Memorandum Opinion* at 5. Nonpayment is a reasonable basis for denying a claim, therefore, Defendant United Olympic Life Insurance Company was justified in refusing to pay Plaintiffs' subsequent claims. Thus, Plaintiffs now seek continued benefits from the policy *they* canceled.

None of the cases cited by Plaintiffs interpret TEX. INS. CODE ANN. art. 3.70-3(B)(6) (Vernon 1981), and Defendant states that it has not uncovered any cases directly on point. However, the Court considers *Tusa v. Prudential Ins. Co. of America*, 825 F.2d 69, 74 (5th Cir. 1987) to be sufficiently analogous to shed light on a resolution of this issue. In *Tusa* the court held that Prudential could not

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[3] The relevant portion of the policy, titled "CANCER BENEFIT," provided:

> The benefits hereunder apply only to services rendered following a pathological diagnosis of cancer; and *for the purpose of benefits under this Rider, a subsequent diagnosis of cancer shall be considered a continuation of the previous cancer.*

Plaintiffs have not directed the Court's attention to any portion of their policy containing the same or similar language.

cancel the Tusas' policy with prejudice to any claim which "matured" during the policy period; specifically, the right to file claims which vested when Amanda Tusa was born with multiple congenital abnormalities. *Id.* at 74. However, the court also set forth the premium and benefit levels which the Tusas would have to pay in order to continue their coverage: "[t]he only practical method available to this court to avoid prejudice to Amanda Tusa is to fix the premium rate *for her continuing coverage* at the amount being paid for her coverage at the inception of her claim . . . " *Id.* at 74 (emphasis added). Indeed, this holding conformed to the prayer of the Tusas, which requested a judgment "[d]eclaring that plaintiff *has the right to purchase, and the defendant has the obligation to sell to plaintiff,* the coverage afforded under the referenced policy, as to Amanda Tusa, as it existed at the time of Amanda's birth . . . " *See Tusa v. Prudential Insurance Co. of America,* 1987 WL 9109 (E.D.La.) (Not reported in F. Supp.) (emphasis added); *see also, Tusa v. Prudential Ins. Co. of America,* 825 F.2d 69, 72 (5th Cir. 1987). Therefore, while the Plaintiffs may have had a right to continued coverage for an illness which originated during the policy period, they lost that right by canceling the policy through nonpayment.[4]

Plaintiffs further contend that the phrase "any claim originating prior" to cancellation includes claims arising before the start-date of the instant policy, or, in the alternative, that Defendant United Olympic Life Insurance

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[4] Plaintiffs canceled the policy *before* the rate increase went into effect.

Company's payment for claims related to illnesses originating prior to the policy resulted in a waiver of its right to exclude Plaintiff Michael Hogue's claims for pre-existing illnesses.

An illness can only "originate" once. Plaintiffs freely admit that all of Mr. Hogue's illnesses "originated" before Plaintiffs obtained insurance from Defendant United Olympic Life Insurance Company. Therefore, Plaintiffs argue, "it is important to notice that in *National Life* the issue was whether or not the illness began 'prior to cancellation' and not merely during the period of coverage." Thus, Plaintiffs assert that an insurance company is liable, after the policy terminates, for illnesses which "originated" before coverage began. The fruition of this theory is that an insurer might exclude pre-existing conditions and correctly avoid claims related to a pre-existing illness during the policy period, yet somehow be liable for such claims after cancellation; similarly, an insured could unilaterally cancel a policy through nonpayment but continue to hold the insurance company forever liable for claims originating before the policy even took effect. This suggestion defies logic and is unsupported by any relevant authority.

Michael Hogue's Hodgkin's disease, rheumatoid arthritis, and prostate problems originated before Plaintiffs were insured by Defendant United Olympic Life Insurance Company. The Hodgkins disease, which is the greatest source of Plaintiffs' claims, originated while Plaintiffs were insured by George Washington Life, which subsequently canceled the policy. Mr. Hogue testified that he has no complaint against George Washington Life now, but that he would have probably sued them if Defendant

United Olympic Life Insurance Company had not sold him a policy. In suing Defendant United Olympic Life Insurance Company on this issue, Plaintiffs' legal efforts are misdirected.

In order to accept Plaintiffs' argument that the "waiver" theory is relevant, the Court would have to find that the illnesses originated once before Defendant United Olympic Life Insurance Company's coverage began, and then again during coverage. If an illness can "originate" once before a policy begins, then again during the policy period because claims are filed, why could the illness not be said to "originate" again when claims related to the illness are filed after the policy ended; Plaintiffs' alleged "waiver" exception swallows their argument. Indeed, *all* of Plaintiffs' cited cases, which are discussed above, in addition to several other cases uncovered by the Court[5], involve an insured whose illness or accident "originated" during the policy term. Defendant United Olympic Life Insurance Company's actions do not change the fact that Mr. Hogue's illnesses "originated" before the coverage began.

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[5] *Stanush v. Aetna Life Ins. Co.*, 538 S.W.2d 648 (Tex.Civ.App. – San Antonio 1976, writ ref'd n.r.e); *Washer v. Continental Casualty Co.*, 418 S.W.2d 900 (Tex.Civ.App. – Houston [14th Dist.] 1967, writ ref'd n.r.e); *American Bankers Ins. Co. v. McDonald*, 369 S.W.2d 688 (Tex.Civ.App. – Austin 1963, writ dism'd w.o.j.); *Maryland Casualty Co. v. Thomas*, 289 S.W.2d 652 (Tex.Civ.App. – Amarillo 1956, writ ref'd n.r.e.); *American Benefit Ass'n v. Russell*, 278 S.W.2d 316 (Tex.Civ.App. 1954, writ dism'd); *Cf. Int'l Sec. Life Ins. Co. v. Arant*, 463 S.W.2d 523 (Tex.Civ.App. – Amarillo 1971, writ ref'd n.r.e.).

In light of the relevant caselaw and the wording of the statute, the only rational construction of Article 3.70-3(B)(6) is that it requires an insurance company to maintain rate and benefit levels for a covered illness as long as the insured continues to pay the premiums. *See Tusa v. Prudential Ins. Co. of America*, 825 F.2d 69, 72 (5th Cir. 1987). A covered illness is one which is both covered by the policy and which "originates" during the policy term. Plaintiffs' arguments in this regard are without merit. Thus, Article 3.70-3(b)(6), which states that the cancellation of any health insurance policy "shall be without prejudice to any claim originating prior to the effective date of cancellation" does not support Plaintiffs' claim for future medical coverage.

As discussed in the Memorandum Opinion, Plaintiffs canceled their insurance with Defendant United Olympic Life Insurance Company by failing to pay their monthly premium before the end of the grace period. This finding and the fact that Plaintiffs failed to prove any wrongdoing on the part of Defendants rendered a discussion of Plaintiffs' claim for declaratory relief unnecessary. Accordingly, Plaintiffs' first request for amendment is denied.

Findings Against the Great Weight and Preponderance of the Evidence

Plaintiffs allege that eight of the Court's findings are contrary to the great weight and preponderance of the evidence. With one exception, Plaintiffs' objections are without merit.

Plaintiffs first request that the Court amend its finding that they obtained group insurance from GIC insurance as a member of a policyholder called "World Wide Consumer Association." Plaintiffs alleged that this finding is against the great weight and preponderance of the evidence because Mrs. Hogue testified otherwise. This request is without merit.

Plaintiffs next request that the Court amend its finding that the application for group insurance with Defendant United Olympic Life Insurance Company was completed on October 31, 1989. The application is dated "10-31-93" above Mr. Hogue's signature. In addition, Plaintiffs wrote a check for their first premium on November 2, 1993. Mrs. Hogue testified that she received the application as an attachment to a November 28, 1989, letter from their local insurance agent. The letter, which is Plaintiffs' exhibit 3a, states that the application must be returned by December 1, 1993. Mrs. Hogue testified that she received the application sometime after November 28, 1989, Mr. Hogue signed it, and then Mrs. Hogue delivered it to Risk Funding Alternatives, Inc. Mrs. Hogue testified that a representative of Risk Funding Alternatives, Inc. told her to back-date the application.

In light of the foregoing, the Court determines that Plaintiff's request for an amended finding has merit. The relevant portion of the Memorandum Opinion states:

> On October 31, 1989, Plaintiffs' coverage was canceled by George Washington, and on that same date, Plaintiffs completed an application for group insurance with Defendant United Olympic Life Insurance Company ("United Olympic"). The application was provided by

> RFA and was an entitled "Risk Funding Alternatives Participating Employer Application Employer Agreement." Two days later Plaintiffs paid their first premium. The Plaintiffs were insured as an employer group, effective November 1, 1989, under a policy issued by United Olympic . . .

That portion will be amended to state the following:

> On October 31, 1989, Plaintiffs' coverage was canceled by George Washington. Plaintiffs paid their first premium for their new policy with a check dated November 2, 1989, and payable to Risk Funding Alternatives in the amount of $225. Plaintiffs received an application for insurance with Defendant United Olympic Life Insurance Company ("United Olympic") sometime [sic] after November 28, 1989, as an attachment to a letter from their local agent explaining that the application must be returned to RFA by December 1, 1989, to insure continued coverage. Mrs. Hogue back-dated her husband's signature to October 31, 1989, and requested that the policy have an effective date of November 1, 1989. The application, entitled "Risk Funding Alternatives Participating Employer Application Employer Agreement," was signed, completed, and delivered to RFA after November 28, 1989, and on or before December 1, 1989. The Plaintiffs were then insured as an employer group, effective November 1, 1989, under a policy issued by United Olympic . . .

This change has no bearing on the Court's Conclusions of Law.

Plaintiffs next request that the Court amend its finding that Plaintiffs were insured as an "employer group."

Plaintiffs allege that this finding is against the great weight and preponderance of the evidence because a September 11, 1990 letter from Defendant Risk Funding Alternatives, Inc. to Baylor University Medical Center seems to state otherwise. This request is without merit.

Plaintiffs request that the Court amend its finding that the "Med Preference II" or "Med Choice II" trust was created on August 1, 1990, and that Defendant United Olympic Life Insurance Company issued a group policy to the new trust. Plaintiffs allege that this finding is against the great weight and preponderance of the evidence because there is no evidence that the trust was created or that a group policy was issued to it. This request is without merit.

Plaintiffs request that the Court re-examine its finding that Plaintiffs were not eligible to apply to the new trust based upon their claims/loss ratio remaining above 80% after the new trust was created. This request is without merit.

Plaintiffs request that the Court re-examine its finding that Plaintiffs remained in the old trust. This request is without merit.

Plaintiffs request that the Court re-examine its finding that the premium increases were based on sound actuarial principles. The Court's Memorandum Opinion stated the following with regard to Mr. Knight's testimony on sound actuarial principles:

> No evidence was presented that the insureds originally in the Old Trust represented the same or similar risk as Mr. Hogue. To the contrary, the only evidence offered on the subject was the

> testimony of Mr. James Knight, former Senior Vice President and Chief Actuary of United Olympic, who stated that the practice of basing rates and benefits on the claims-loss ratio is grounded in "sound actuarial principles." *At best, discounting the testimony of Mr. Knight,* Mr. Hogue's "class" was composed of insureds who presented a risk similar to that of a person in remission from Hodgkin's disease and suffering rheumatoid arthritis and prostate problems. Therefore, given the fact that no evidence was submitted to support the conclusions that members of the Plaintiffs' class had lower premiums or better benefits, Plaintiffs failed to prove by a preponderance of the credible evidence that Defendants unfairly discriminated against them.

(emphasis added). The Court did not rely on Mr. Knight's testimony, but rather based its holding on Plaintiffs' failure to produce sufficient evidence to meet their burden. This request is wholly without merit.

Finally, Plaintiffs state that footnote 6 on the bottom of page 21 of the Memorandum Opinion is incorrect and should be modified. Plaintiffs are correct in this assertion. Because of a clerical error, the stop-loss figures and rounded premium dollar figures were erroneously reported. Footnote 6 was a chart that contained the following information:

The premium and benefit changes are outlined in the following chart:

Begin Date	Co-payment	Stop-loss	Health Premium	Δ rate
11/89	80%	$10,000	$ 192	
7/90	80%	$ 5,000	$ 226	18%
2/91	60%	$ 5,000	$ 226	
3/91	60%	$ 5,000	$1,151	413%

The footnote will now read:

[6]The premium and benefit changes are outlined in the following chart:

Begin Date	Co-payment	Stop-loss	Health Premium	Δ rate
11/89	80%	$ 5,000	$ 192	
7/90	80%	$10,000	$ 224.56	18%
2/91	60%	$10,000	$ 224.56	
3/91	60%	$10,000	$1,151.99	413%

In addition, *sua sponte*, the figures "$226" or "approximately $226" cited throughout the opinion, will be changed to "$224.56". These changes have no bearing on the Court's Conclusions of Law.

Unconscionability

Plaintiffs' argument regarding unconscionability is grounded in part in their erroneous interpretation of TEX. INS. CODE ANN. art. 3.70-3(B)(6) (Vernon 1981). The balance of Plaintiffs' argument is identical to that presented during the trial of this matter. Therefore, this request for review is without merit.

Discrimination

Plaintiffs' argument regarding their claim of unfair discrimination centers on the Court's application of *Reeves v. New York Life Ins. Co.*, 421 S.W.2d 686 (Tex.Civ.App. – Dallas 1967, writ ref'd n.r.e.), which is the only case in Texas construing TEX. INS. CODE. ANN. art 21.21 §4(7)(b). In that case New York Life Insurance Company denied Reeves' claim based upon an exclusionary rider to the policy. Reeves claimed that the exclusion violated Article 21.21 §4(7)(b) because he paid the same premium as other insureds, but suffered reduced coverage. In construing clause 7(b), the court held that "individuals of the same class and of essentially the same hazard" were those who, like the insured, had a history of lower back and knee problems." Reeves did not present evidence that other individuals in the same "class" were charged lower premiums. The court added:

> To increase the premium for taking the risk for such a cause is not a discrimination, but a reasonable difference. If a higher premium for an increased risk were made unlawful, a person whose health is thus impaired could get no insurance.

Id. at 688, *quoting Hilson v. Sun Life Assurance Co.*, 132 F.2d 989 (5th Cir. 1943).

Plaintiffs distinguished *Reeves* because the alleged discrimination in that case was based on a specific medical condition: a herniated disk. In the instant case the distinction was made based only on the claims-loss ratio for each employer group. This Court held that Plaintiffs failed to produce any evidence to support their claim that other similarly-situated insureds received greater benefits

for lesser premiums under §4(7)(b). This Court assumed, *arguendo*, that a claims-loss ratio is not health-related, and further assumed that the New Trust/Old Trust dichotomy was illusory; and given those assumptions, held that Plaintiffs did not meet their burden to show that insureds who enjoyed lower premiums and/or higher benefits were members of the same "class" as Mr. Hogue.

Plaintiffs now seek to distinguish *Reeves* on other facts. Plaintiffs construe *Reeves* to simply hold that "the insurance company specifically excluded those conditions up front and the Court merely required Mr. Reeves to honor the exclusions that he had agreed to." Having carefully re-examined *Reeves* and its application in this case, the Court concludes that the differing facts cited by Plaintiff are immaterial to the Court's application of that case, and that Plaintiffs' strongly-worded denunciation of the Court's construction and application of that case is unwarranted.

Misrepresentations

Plaintiffs complain that the Court erred in failing to consider Plaintiffs' exhibits 48 and 49 in regard to their claims of misrepresentation.[6] The Court considered three

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[6] Plaintiffs quote a portion of exhibit 48 which states "[w]e are confident that our future rates and benefits will stabilize," and part of exhibit 49 which states that "[w]hile many other insurance companies are being forced to announce unreasonable increases in premium[s] and reduction[s] of benefits, we hope you can share in the excitement of a positive development of this magnitude." The letters, dated October 31, 1989, and October 13, 1989, respectively, are from Risk Funding Alternatives, Inc. to its insureds.

other exhibits that were presented at trial. During the trial of this matter Mrs. Hogue testified that she thought Plaintiffs' exhibit 2 was a representation that Plaintiffs' premiums would not go up very quickly once Defendant United Olympic Life Insurance Company issued a policy to them.[7] After questioning Mrs. Hogue about exhibit 2, Defense Counsel asked her whether she understood, after seeing exhibits 48 and 49, that the company referred to in exhibit 2 was Defendant United Olympic Life Insurance Company; she answered yes.[8] Her discussion of exhibit

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[7] Exhibit 2 is a letter dated September 29, 1989, from Risk Funding Alternatives, Inc. to Plaintiffs announcing its affiliation with Defendant United Olympic Life Insurance Company. It explains some of the details of changes necessitated by termination of the George Washington policy, and includes the following language:

> Our goal at Risk Funding Alternatives has one purpose . . . "To provide the finest service in the health insurance industry," and adding this "A+ Superior" rated company [United Olympic] to our network of coverage brings an extra level of security in these troubled times. . . . While many other insurance companies are being forced to announce unreasonable increases in premium[s] and reductions[s] [sic] in benefits, we hope that you can share in the excitement of a positive development of this magnitude. And before the end of the year, we will announce the development of new options to help control your health insurance cost, while maintaining quality service.

The Court found that the alleged misrepresentations contained in this letter were mere "puffing," and not actionable under either §17.46(b)(5) of the Commerce Code or Article 21.21 §4(1) of the Insurance Code.

[8] Both letters specifically named "United Olympic Life Insurance Company" in regard to Risk Funding Alternative,

48 was limited to answering that question. She stated that exhibit 49 was same type of letter. Later, Mrs. Hogue was asked to read paragraph 2 of exhibit 49.[9] However, she did not explain how or if she was mislead by those communications.[10] The Court is not required nor empowered to infer evidence. Therefore, the Court properly disregarded exhibits 48 and 49 in its analysis of Plaintiffs' misrepresentation claims.

Inc.'s "proud announcement" and "exciting news" that a new carrier would be insuring them.

[9] Paragraph 2 of exhibit 49 states:

> After weeks of comparing companies, we selected United Olympic Life because it has a history of reliability and fairness – and its coverage is backed by more than half a BILLION dollars in assets.

[10] Plaintiffs' Proposed Findings of Fact and Conclusions of Law similarly failed to discuss any alleged misrepresentation relating to exhibits 48 and 49. Plaintiffs' Proposed Finding of Fact which related to misrepresentation state simply:

> 23. In splitting the Med Preference Trust into two groups, [United Olympic Life Insurance Co.] and [Consultants and Administrators, Inc./Delaware Administrators, Inc.] failed to state material facts that were necessary to prevent statements made from being misleading which was a producing cause of damages to Plaintiffs (28 TEX. ADMIN. CODE § 21.4(2))[.]
>
> 24. Such failure to state material facts was knowingly committed by [United Olympic Life Insurance Company] and [Consultants and Administrators, Inc./Delaware Administrators, Inc.].

The related Conclusion of Law states:

> 3. Defendants' conduct in failing to disclose the separation of the Med Preference Trust into "the new trust" and "the old trust" violates 28 TEX. ADMIN. CODE 21.4(2).

Breach of Duty oF Good Faith and Fair Dealing

Plaintiffs finally allege that the Court is mistaken to the extent that it considers the duty of good faith and fair dealing to only require that benefits be promptly paid. Plaintiffs quote definitions of "good faith" from BLACK'S LAW DICTIONARY 623-624 (5th ed. 1981) and TEX. BUS. & COM. CODE ANN. § 1.201(19) in support of their theory.[11]

The Texas Supreme Court created a cause of action for breach of the duty of good faith and fair dealing in the insurance context in the case of *Arnold v. National County Mut. Fire Ins. Co.*, 725 S.W.2d 165, 167 (Tex. 1987), which is

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[11] Plaintiffs aver that BLACK'S LAW DICTIONARY defines good faith as encompassing, among other things,"

> . . . an honest belief, the absence of malice and the absence of design to defraud or to seek an unconscionable advantage . . . Honesty of intentions, and freedom from knowledge of circumstances which ought to put the holder on inquiry. An honest intention to abstain from taking any unconscientious advantage of another, even through technicalities of law, together with the absence of all information, notice, or benefit or belief of facts which would render [a] transaction unconscientious. In common usage this terms is ordinarily used to describe that state of mind denoting honesty of purpose, freedom from intention to defraud, and, generally speaking, means being faithful to one's duty or obligation.

Section 1.201(19) of the TEX. BUS. & COM. CODE ANN. defines good faith as "honesty in fact in the conduct or transaction concerned."

While these definitions may assist in explaining Defendants' duty in handling Plaintiffs' claims, it is unclear how they are relevant to a discussion of whether the duty should be expanded to include other activities.

cited as authority in the Memorandum Opinion. The court based its decision on the following:

> In the insurance context a special relationship arises out of the parties' unequal bargaining power and the nature of insurance contracts which would allow unscrupulous insurers to take advantage of insureds' misfortunes in bargaining for settlement or resolution of claims. In addition, without such a cause of action insurers can arbitrarily deny coverage and delay payment of a claim with no more penalty than interest on the amount owed. An insurance company has exclusive control over the evaluation, processing and denial of claims.

Id. at 167. The reasons for the creation of the cause of action were to protect insureds "in bargaining for settlement or resolution of claiims," and to prevent insurers from arbitrarily "deny[ing] coverage and delay[ing] payment." The Court defined the cause of action thus:

> A cause of action for breach of the duty of good faith and fair dealing is stated when it is alleged that there is no reasonable basis for denial of a claim or delay in payment or a failure on the part of the insurer to determine whether there is any reasonable basis for the denial or delay.

Id.

The Fifth Circuit, considering the "common law duty of good faith and fair dealing imposed on an insurer," recently held that "[e]very Texas Court considering the question agrees that an insurer only breaches its duty of good faith and fair dealing when it lacks a reasonable basis for denying or delaying payment of the claim or when it should have known that no such basis existed."

Thrash v. State Farm Fire & Casualty Co., No. 92-4054 (5th Cir. May 28, 1993). This Court has examined several cases decided after *Arnold* on the subject of the scope of the duty, and has concluded that there was, and is, no basis for Plaintiffs' claim that the duty should be expanded. *See, Eg., Shelton Ins. Agency v. St. Paul Mercury Ins. Co.*, 848 S.W.2d 739, 743 (Tex.App. – Corpus Christi 1993, writ denied). Plaintiffs' final claim is without merit.

Conclusion

Plaintiffs' request for a declaratory judgment on the issue of whether Defendant United Olympic Life Insurance Company is obligated to provide future coverage for rheumatoid arthritis, prostate problems, and Hodgkins disease is foreclosed by the Fifth Circuit's ruling in *Tusa v. Prudential Ins Co. Of America*, 825 F.2d 69, 72 (5th Cir. 1987) and this Court's interpretation of TEX. INS. CODE ANN. art. 3.70-3(B)(6) (Vernon 1981). Plaintiffs' requests for amended findings of fact are without merit with two exceptions regarding clerical errors which are not material to the Court's Conclusions of Law and disposition of this case. Plaintiffs' request for amended findings regarding their claims of unconscionability, unfair discrimination, misrepresentation, and breach of the duty of good faith and fair dealing are without merit.

Based on the foregoing, Plaintiffs' Motion for New trial is denied.

Accordingly, it is

ORDERED that Plaintiffs' Motions for Additional Findings pursuant to Rule 52(b), FED. R. CIV. P. (docket

#56-1) filed On August 26, 1993, is **GRANTED IN PART**. The Court's changes to the Memorandum Opinion (docket #54) filed on August 11, 1993, are outlined above, and a corrected copy of that document is attached hereto for the convenience of the parties. It is further

ORDERED that Plaintiffs' Motion for New Trial Pursuant to Rule 59, FED. R. CIV. P. (docket #56-2) filed on August 26, 1993, is **DENIED**.

SIGNED this 24th day of September, 1993.

/s/ Judith K. Guthrie
JUDITH K. GUTHRIE
UNITED STATES
MAGISTRATE JUDGE

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

MICHAEL HOGUE, ET AL.	§	CIVIL ACTION NO. 6:92cv595
V.	§	(Filed Jan. 27, 1993)
UNITED OLYMPIC LIFE INSURANCE CO.	§	

ORDER

Came on for consideration Defendant's Motion to Strike Jury Demand (docket #14) filed December 14, 1992. Defendants assert that Plaintiffs failed to preserve their right to a jury trial because the demand was filed later than ten days after removal of the case to federal court.

Plaintiffs filed their response (docket #17) on December 22, 1992. Plaintiffs counter that their demand was filed within ten days after Defendants' Supplemental Notice of Removal, and that the demand was thus filed within ten days after Defendants' Notice of Removal within the meaning of Rule 81(c).

Rule 81(c) of the Fed.R.Civ.P. governs the timing of jury demands made after removal. It provides in part:

> If at the time of removal all necessary pleadings have been served, a party entitled to trial by jury under Rule 38 shall be accorded it, if the party's demand therefor is served within ten days after the petition for removal is filed if the party is the petitioner, or if not the petitioner,

within ten days after service on the party of the notice of filing the petition.

In this case the Notice of Removal was filed September 18, 1992, asserting that Plaintiffs' claims were preempted by the Employee Retirement Income Security Act of 1974, 29 U.S.C. 1144, and that the Court had jurisdiction based upon federal questions presented by that Act. On September 25, 1992, Plaintiffs filed their Motion to Remand due to the absence of any federal question; later, on October 6, 1992, Defendants filed a Supplemental Notice of Removal based upon diversity of citizenship. And on that same day, October 6, 1992, Plaintiff's filed their jury demand.

The language of Rule 81(c) clearly requires a party to make its demand for a jury within ten days after the petition for removal is filed. The time limit is not tolled by filing a Motion to Remand, however meritorious that motion may be. Indeed, by making the Rule 81(c) time limitation so short, it is apparent that its drafters sought to discourage parties from betting on the success of their Motion to Remand at the expense of a timely jury demand, and to encourage certainty by setting a precise time limit.

Defendants' Notice of Removal was filed September 18, 1992; therefore, Plaintiffs' demand for a jury trial, filed October 6, 1993, was not timely. Accordingly, it is

ORDERED that Defendants' Motion to Strike Jury Demand (docket #14) is **GRANTED.**

SIGNED this 27th day of January, 1993.

/s/ Judith K. Guthrie
JUDITH K. GUTHRIE
UNITED STATES
MAGISTRATE JUDGE

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

MICHAEL HOGUE AND CAROL HOGUE, Plaintiffs, vs. UNITED OLYMPIC LIFE INSURANCE COMPANY; DELAWARE ADMINISTRATORS, FORMERLY CONSULTANTS & ADMINISTRATORS, INC., Defendants.	Civil Action No. 6:92cv595 (Filed Oct. 29, 1992)

ORDER

Before the Court are: Plaintiffs' Motion for Remand; and Defendants' Response to Plaintiffs' Motion for Remand.

I. Analysis

It is true that Defendants have wholly failed to meaningfully rebut Plaintiffs' assertion that the insurance policy in question is *not* an ERISA-regulated plan (*i.e.*, because it does not meet the requirements of 29 U.S.C. §§ 1002(1) and 1003 – which provisions require that a plan be established or maintained by an employer or employee organization, or both). (Plaintiffs have asserted that the insurance policy in question was neither established nor

maintained by either of their employers, or by any employee organization in which they were members. Rather, Plaintiffs assert, the policy is question was acquired by Plaintiffs as individuals, and not as participants or beneficiaries in an employee benefit plan.) Defendants have merely asserted in a blanket, or conclusory fashion that this is an ERISA case. Hornbooks teach that this is inadequate. *See e.g.*, Charles Alan Wright, Law of Federal Courts 235 (4th ed. 1983) ("Any issues of fact raised by a motion are for the court to decide, *with the removing party carrying the burden of proof.*") (emphasis added). *See also* 14 Wright, Miller and Cooper, Jurisdiction § 3739 nn. 22-23 and cases cited therein.

Moreover, Defendants' contention notwithstanding, there is in fact no indication in Defendants' Notice of Removal that Defendants removed this cause of action on the basis of this Court's *diversity* jurisdiction (*i.e.*, in addition to this Court's alleged federal question (ERISA-based) jurisdiction).

Yet, it does appear that this Court possesses diversity jurisdiction over this action. Apparently, Plaintiffs are citizens of Texas while Defendants are citizens of Washington and Delaware. And while Defendants bear the burden of showing that the required amount is in controversy, Defendants' burden in this respect is a light one. Defendants must show only that it does not appear to a *legal certainty* that the claim is for less than the jurisdictional amount. *St. Paul Indemnity Co. v. Cab Co.*, 303 U.S. 283, 288 (1938). And a *reasonable reading* of Plaintiffs' state court complaint evidences – consistent with the "legal

certainty" test – a strong likelihood that the requisite amount in controversy exists in this case.

II. Conclusion

It appearing that Defendants have properly removed this case pursuant to this Court's diversity jurisdiction, it is hereby **ORDERED, ADJUDGED AND DECREED** that Plaintiffs' Motion to Remand is **DENIED.**

So Ordered.

Signed This the 29th Day of October , 1992.

/s/ Robert M. Parker
HONORABLE
ROBERT M. PARKER
CHIEF UNITED STATES
DISTRICT COURT JUDGE
EASTERN DISTRICT
OF TEXAS

APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
TYLER DIVISION

MICHAEL HOGUE AND CAROL HOGUE	§	CIVIL ACTION
	§	NO. 6:92CV595
V.	§	
UNITED OLYMPIC LIFE INSURANCE COMPANY, DELAWARE ADMINISTRATORS, AND CONSULTANTS AND ADMINISTRATORS, INC.	§	

FINAL JUDGMENT

(Filed Aug. 11, 1993)

The Court having considered Plaintiffs' case and rendered its decision by opinion issued this same date, it is hereby **ORDERED** that Plaintiffs take nothing by his suit and that the same is **DISMISSED** with prejudice. All motions by either party not previously ruled on are hereby **DENIED.**

SIGNED this 11th day of August, 1993.

/s/ Judith K. Guthrie
JUDITH K. GUTHRIE
UNITED STATES
MAGISTRATE JUDGE

APPENDIX H

U. S. Const. amend. VII

AMENDMENT 7

Trial by jury in civil cases.

In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.

Federal Rules of Civil Procedure Rule 38(b)

Rule 38. Jury trial of right

(a) Right preserved. The right of trial by jury as declared by the Seventh Amendment to the Constitution or as given by a statute of the United States shall be preserved to the parties inviolate.

(b) Demand. Any party may demand a trial by jury of any issue triable of right by a jury by (1) serving upon the other parties a demand therefor in writing at any time after the commencement of the action and not later than 10 days after the service of the last pleading directed to the issue, and (2) filing the demand as required by Rule 5(d). Such demand may be endorsed upon a pleading of the party.

Federal Rules of Civil Procedure Rule 81(c)

Rule 81

(c) Removed actions. These rules apply to civil actions removed to the United States district courts from the state courts and govern procedure after removal. Repleading is not necessary unless the court so orders. In a removed action in which the defendant has not answered, the defendant shall answer or present the other defenses or objections available under these rules within 20 days after the receipt through service or otherwise of a copy of the initial pleading setting forth the claim for relief upon which the action or proceeding is based, or within 20 days after the service of summons upon such initial pleading, then filed, or within 5 days after the filing of the petition for removal, whichever period is longest. If at the time of removal all necessary pleadings have been served, a party entitled to trial by jury under Rule 38 shall be accorded it, if the party's demand therefor is served within 10 days after the petition for removal is filed if the party is the petitioner, or if not the petitioner within 10 days after service on the party of the notice of filing the petition. A party who, prior to removal, has made an express demand for trial by jury in accordance with state law, need not make a demand after removal. If state law applicable in the court from which the case is removed does not require the parties to make express demands in order to claim trial by jury, they need not make demands after removal unless the court directs that they do so within a specified time if they desire to claim trial by jury. The court may make this direction on its own motion and shall do so as a matter of course at the request of any party. The failure of a party to make

demand as directed constitutes a waiver by that party of trial by jury.

Tex. Ins. Code art. 3.51-6(1)(a)(1-5)

Art. 3.51-6. Group and Blanket Accident and Health Insurance

Group Insurance Defined; Coverage; Certificate; Fees or Allowances; Required Provisions; Conversion or Continuation of Policies

Sec. 1. (a) Group accident and health insurance is hereby defined to be that form of accident, sickness, or accident and sickness insurance covering groups of persons as provided in Subdivisions (1) through (6) below:

(1) under a policy issued to an employer or trustees of a fund established by an employer, who shall be deemed the policyholder, insuring employees of such employer for the benefit of persons other than the employer. The term "employees" as used herein shall be deemed to include the officers, managers, and employees of the employer, the individual proprietor, or partner if the employer is an individual proprietor or partnership, the officers, managers, and employees of subsidiary or affiliated corporations, the individual proprietors, partners, and employees of individuals and firms, if the business of the employer and such individual or firm is under common control through stock ownership, contract, or otherwise, and retired employees. A policy issued to insure employees of a public body may provide that the

term "employees" shall include elected or appointed officials. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(2) under a policy issued to an association, including but not limited to a labor union or organizations of such unions, membership corporations organized or holding a certificate of authority under the Texas Non-Profit Corporation Act, and cooperatives and corporations subject to the supervision and control of the Farm Credit Administration of the United States of America, and which association shall have a constitution and bylaws, which has been organized and has had an active existence for at least two years, and which is maintained in good faith for purposes other than that of obtaining insurance, to insure members, employees, or employees of members (active and retired for the benefit of persons other than the association or its offices or trustees);

(3) under a policy issued to the trustees of a fund established by two or more employers in the same or related industry or by one or more labor unions or by one or more employers and one or more labor unions or by an association as defined in (2) above, which trustees shall be deemed the policyholder, to insure employees of the employers or members of the unions or such association, or employees or members of such association for the benefit of persons other than the employers or the unions or such association. The term "employees" as used herein may include the officers, managers, and employees of the

employer, retired employees, and the individual proprietor or partners if the employer is an individual proprietor or partnership. The policy may provide that the term "employees" shall include the trustees or their employees, or both, if their duties are principally connected with such trusteeship;

(4) under a policy issued to any person or organization to which a policy of group life insurance may be issued or delivered in this state to insure any class or classes of individuals that could be insured under such group life policy;

(5) under a policy issued by an insurer to a trustee of a fund, which shall be deemed to be the policyholder, to insure former employees, former members, their spouses, former spouses, and their dependents, who were previously insured by such insurer under a policy issued to any of the groups provided for in this article;

* * *

Tex. Ins. Code art. 3.70-3(B)(6)

(B) Other Provisions. Except as provided in paragraph (C) of this section, no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth below unless such provisions are in the words in which the same appear in this section; provided, however, that the

insurer may, at its option, use in lieu of any such provision a provision of different wording approved by the Board, in accordance with reasonable rules and regulations promulgated by the Board, which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in this subsection or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the Board may approve.

* * *

(6) A provision as follows:

Cancellation: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to his last address as shown by the records of the insurer, stating when, not less than five days thereafter, such cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on such later date as may be specified in such notice. In the event of cancellation, the insurer will return promptly the unearned portion of any premium paid. If the insured cancels, the earned premium shall be computed by the use of the short-rate table last filed with the state official having supervision of insurance in the state where the insured resided when the policy was issued. If the insurer cancels, the earned premium shall be computed pro-rata. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

Tex. Ins. Code art. 21.21 § 1

Art. 21.21. Unfair Competition and Unfair Practices

Declaration of Purpose

Sec. 1. (a) The purpose of this Act is to regulate trade practices in the business of insurance in accordance with the intent of Congress as expressed in the Act of Congress of March 9, 1945. (Public Law 15, 79th Congress), by defining, or providing for the determination of, all such practices in this state which constitute unfair methods of competition or unfair or deceptive acts or practices and by prohibiting the trade practices so defined or determined.

(b) This Article shall be liberally construed and applied to promote its underlying purposes as set forth in this section.

Art. 21.21. Unfair Competition and Unfair Practices

Tex. Ins. Code art. 21.21 § 4(7)

Sec. 4. The following are hereby defined as unfair methods of competition and unfair and deceptive acts or practices in the business of insurance:

* * *

(7) Unfair Discrimination. (a) Making or permitting any unfair discrimination between individuals of the same class and equal expectation of life in the rates

charged for any contract of life insurance or of life annuity or in the dividends or other benefits payable thereon, or in any other of the terms and conditions of such contract;

(b) Making or permitting any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contact, or in any other manner whatever;

(c) Making or permitting any unfair discrimination between individuals or risks of the same class and of essentially the same hazards by refusing to renew, cancelling or limiting the amount of coverage on a policy of insurance covered by Subchapter C, Chapter 5, of this code because of the geographic location of the risk unless:

(1) the refusal, cancellation or limitation is for a business purpose that is not a mere pretext for unfair discrimination; or

(2) the refusal, cancellation or limitation is required by law or regulatory mandate.

Tex. Ins. Code art. 21.21 § 16

Relief Available to Injured Parties

Sec. 16. (a) Any person who has sustained actual damages as a result of another's engaging in an act or practice declared in Section 4 of this Article or in rules or regulations lawfully adopted by the Board under this Article to be unfair methods of competition or unfair or deceptive acts or practices in the business of insurance or in any practice defined by Section 17.46 of the Business & Commerce Code, as amended, as an unlawful deceptive trade practice may maintain an action against the person or persons engaging in such acts or practices.

(b) In a suit filed under this section, any plaintiff who prevails may obtain:

(1) the amount of actual damages plus court costs and reasonable and necessary attorneys' fees. If the trier of fact finds that the defendant knowingly committed the acts complained of, the court shall award, in addition, two times the amount of actual damages; or

(2) an order enjoining such acts or failure to act; or

(3) any other relief which the court deems proper.

(c) On a finding by the court that an action under this section was groundless and brought in bad faith or brought for the purpose of harassment, the court shall award to the defendant reasonable and necessary attorneys' fees and court costs.

(d) All actions under this Article must be commenced within two years after the date on which the unfair method of competition or unfair or deceptive act

or practice occurred or within two years after the person bringing the action discovered or, in the exercise of reasonable diligence, should have discovered the occurrence of the unfair method of competition or unfair or deceptive act or practice. The period of limitation provided in this section may be extended for a period of 180 days if the person bringing the action proves that the failure to timely commence the action was caused by the defendant's engaging in conduct solely calculated to induce the plaintiff to refrain from or postpone the commencement of the action.

(e) As a prerequisite to filing a suit seeking damages under this section against any person, the person seeking damages shall give written notice to the other person at least 30 days before filing suit. The notice must advise the person of the specific complaint and the amount of actual damages and expenses, including any attorneys' fees reasonably incurred in asserting the claim against the defendant.

(f) If giving 30 days' written notice is impracticable because the suit must be filed in order to prevent the expiration of the statute of limitations or because the claim is asserted as a counterclaim, the notice provided for in Subsection (e) of this section is not required, and the tender of a written offer of settlement provided for by Subsection (g) of this section may be made not later than the 30th day after the date of filing of the suit or counterclaim.

(g) A person who receives the written notice provided by Subsection (e) of this section may tender, not later than the 30th day after the date of receipt of the

notice, to the person seeking damages, a written offer of settlement, including an agreement to reimburse the person for any attorneys' fees reasonably incurred in asserting the claim to the date of the written notice. A person who does not receive a written notice because the suit or counterclaim is filed as provided for by Subsection (f) of this section may tender, not later than the 30th day after the date of filing of the suit or counterclaim, a written offer of settlement, including an agreement to reimburse the person for any attorneys' fees reasonably incurred in asserting the claim to the date the suit or counterclaim was filed. An offer of settlement is rejected if it is not accepted on or before the 30th day after the date of receipt by the person seeking damages.

(h) A rejected settlement offer made in compliance with Subsection (g) of this section may be filed with the court with an affidavit certifying its rejection. If the court finds that the amount tendered in the settlement offer is the same or substantially the same as the actual damages found by the trier of fact, the plaintiff may not recover an amount that exceeds the lesser of:

(1) the amount tendered in the settlement offer; or

(2) the amount of actual damages found by the trier of fact.

(i) The tender of an offer of settlement is not an admission of engaging in an unlawful act or practice or of liability under this Article. Evidence of a settlement offer may be introduced only to determine the reasonableness of the settlement offer as provided for by Subsection (h) of this section.

Tex. Bus. & Com. Code § 17.44

§ 17.44. Construction and Application

This subchapter shall be liberally construed and applied to promote its underlying purposes, which are to protect consumers against false, misleading, and deceptive business practices, unconscionable actions, and breaches of warranty and to provide efficient and economical procedures to secure such protection.

Texas Deceptive Trade Practices –
Consumer Protection Act
(Tex. Bus. & Com. Code § 17.41 et seq.)
Section 17.45(5)

§ 17.45. Definitions

As used in this subchapter:

* * *

(5) "Unconscionable action or course of action" means an act or practice which, to a person's detriment:

(A) takes advantage of the lack of knowledge, ability, experience, or capacity of a person to a grossly unfair degree; or

(B) results in a gross disparity between the value received and consideration paid, in a transaction involving transfer of consideration.

**Texas Deceptive Trade Practices –
Consumer Protection Act
(Tex. Bus. & Com. Code § 17.41 et seq.)
Section 17.46**

§ 17.46. Deceptive Trade Practices Unlawful

(a) False, misleading, or deceptive acts or practices in the conduct of any trade or commerce are hereby declared unlawful and are subject to action by the consumer protection division under Sections 17.47, 17.58, 17.60, and 17.61 of this code.

(b) Except as provided in Subsection (d) of this section, the term "false, misleading, or deceptive acts or practices" includes, but is not limited to, the following acts:

(1) passing off goods or services as those of another;

(2) causing confusion or misunderstanding as to the source, sponsorship, approval or certification of goods or services;

(3) causing confusion or misunderstanding as to affiliation, connection, or association with, or certification by, another;

(4) using deceptive representations or designations of geographic origin in connection with goods or services;

(5) representing that goods or services have sponsorship, approval, characteristics, ingredients, uses, benefits, or quantities which they do not have or that a person has a sponsorship, approval, status, affiliation, or connection which he does not;

(6) representing that goods are original or new if they are deteriorated, reconditioned, reclaimed, used, or secondhand;

(7) representing that goods or services are of a particular standard, quality, or grade, or that goods are of a particular style or model, if they are of another;

(8) disparaging the goods, services, or business of another by false or misleading representation of facts;

(9) advertising goods or services with intent not to sell them as advertised;

(10) advertising goods or services with intent not to supply a reasonable expectable public demand, unless the advertisements disclosed a limitation of quantity;

(11) making false or misleading statements of fact concerning the reasons for, existence of, or amount of price reductions;

(12) representing that an agreement confers or involves rights, remedies, or obligations which it does not have or involve, or which are prohibited by law;

(13) knowingly making false or misleading statements of fact concerning the need for parts, replacement, or repair service;

(14) misrepresenting the authority of a salesman, representative or agent to negotiate the final terms of a consumer transaction;

(15) basing a charge for the repair of any item in whole or in part on a guaranty or warranty instead of on the value of the actual repairs made or work to be performed on the

item without stating separately the charges for the work and the charge for the warranty or guaranty, if any;

(16) disconnecting, turning back, or resetting the odometer of any motor vehicle so as to reduce the number of miles indicated on the odometer gauge;

(17) advertising of any sale by fraudulently representing that a person is going out of business;

(18) using or employing a chain referral sales plan in connection with the sale or offer to sell of goods, merchandise, or anything of value, which uses the sales technique, plan, arrangement, or agreement in which the buyer or prospective buyer is offered the opportunity to purchase merchandise or goods and in connection with the purchase receives the seller's promise or representation that the buyer shall have the right to receive compensation or consideration in any form for furnishing to the seller the names of other prospective buyers if receipt of the compensation or consideration is contingent upon the occurrence of an event subsequent to the time the buyer purchases the merchandise or goods;

(19) representing that a guarantee or warranty confers or involves rights or remedies which it does not have or involve, provided, however, that nothing in this subchapter shall be construed to expand the implied warranty of merchantability as defined in Sections 2.314 through 2.318 of the Business & Commerce Code to involve obligations in excess of those which are appropriate to the goods;

(20) selling or offering to sell, either directly or associated with the sale of goods or services, a right of participation in a multi-level distributorship. As used herein, "multilevel distributorship" means a sales plan for the distribution of goods or services in which promises of rebate or payment are made to individuals, conditioned upon those individuals recommending or securing additional individuals to assume positions in the sales operation, and where the rebate or payment is not exclusively conditioned on or in relation to proceeds from the retail sales of goods;

(21) representing that work or services have been performed on, or parts replaced in, goods when the work or services were not performed or the parts replaced;

(22) filing suit founded upon a written contractual obligation of and signed by the defendant to pay money arising out of or based on a consumer transaction for goods, services, loans, or extensions of credit intended primarily for personal, family, household, or agricultural use in any county other than in the county in which the defendant resides at the time of the commencement of the action or in the county in which the defendant in fact signed the contract; provided, however, that a violation of this subsection shall not occur where it is shown by the person filing such suit he neither knew or had reason to know that the county in which such suit was filed was neither the county in which the defendant resides at the commencement of the suit nor the county in which the defendant in fact signed the contract;

(23) the failure to disclose information concerning goods or services which was known at the time of the transaction if such failure to disclose such information was intended to induce the consumer into a transaction into which the consumer would not have entered had the information been disclosed; or

(24) using the term "corporation," "incorporated," or an abbreviation of either of those terms in the name of a business entity that is not incorporated under the laws of this state or another jurisdiction.

(c)(1) It is the intent of the legislature that in construing Subsection (a) of this section in suits brought under Section 17.47 of this subchapter the courts to the extent possible will be guided by Subsection (b) of this section and the interpretations given by the Federal Trade Commission and federal courts to Section 5(a)(1) of the Federal Trade Commission Act [15 U.S.C.A. § 45(a)(1)].

(2) In construing this subchapter the court shall not be prohibited from considering relevant and pertinent decisions of courts in other jurisdictions.

(d) For the purposes of the relief authorized in Subdivision (1) of Subsection (a) of Section 17.50 of this subchapter, the term "false, misleading, or deceptive acts or practices" is limited to the acts enumerated in specific subdivisions of Subsection (b) of this section.

Texas Deceptive Trade Practices –
Consumer Protection Act
(Tex. Bus. & Com. Code § 17.41 et seq.)
Section 17.50(a)

§ 17.50 Relief for Consumers

(a) A consumer may maintain an action where any of the following constitute a producing cause of actual damages:

* * *

(1) the use or employment by any person of a false, misleading, or deceptive act or practice that is specifically enumerated in a subdivision of Subsection (b) of Section 17.46 of this subchapter;

(2) breach of an express or implied warranty;

(3) any unconscionable action or course of action by any person; or

(4) the use or employment by any person of an act or practice in violation of Article 21.21, Texas Insurance Code, as amended, or rules or regulations issued by the State Board of Insurance under Article 21.21, Texas Insurance Code, as amended.

APPENDIX I

MONTH/YEAR	CO-INSURANCE	STOP LOSS	HEALTH PREMIUM AMOUNT	TOTAL PREMIUM AMOUNT	REFERENCE
November 1989	80%	$5,000.00	$192.00	$225.00	Initial Coverage
February 1990	80%	$5,000.00	$192.00	$223.50	
April 1990	80%	$5,000.00	$192.00	$225.25	
July 1990	80%	$5,000.00	$224.56	$265.81	Notified on May 24, 1990
January 1991	80%	$5,000.00	$224.56	$265.81	Last Premium paid on January 7, 1991
February 1991	**60%**	**$10,000.00**	$224.56	$265.81	Notified on November 29, 1990
March 1991	**60%**	**$10,000.00**	**$1,151.99**	**$1,193.24**	Notified on January 22, 1991

APPENDIX J

Consultants & Administrators, Inc.
P.O. Box 1005
Delaware, Ohio 43015-7105
614-436-6880

July 30, 1990

Marie Hubbard
Complaints Examiner
Texas State Board of Insurance
1110 San Jacinto Street
Austin, TX 78701-1998

RE: MDC No. 26-Hubbard
Insured: Sharmin Polansky
Group No. R0495
Group Name: Zimmerman, Roth & Rosato

Dear Ms. Hubbard:

Your letter of June 27, 1990, to United Olympic Life Insurance Company has been forwarded to us as the administrator of the plan of insurance covering the above employer group.

Because of a much higher than expected utilization of plan benefits, the entire multiple employer trust to which Zimmerman, Roth & Rosato belong has experienced significant rate increases. These increases vary according to the economic and geographic location of the employers. Howver [sic], on the whole, all employers in the trust have received large rate increases. Trend factors are calculated by our staff at Consultants & Administrators, Inc., and forwarded to a consulting actuary firm which reviews our trend factors and establishes a [sic] new premium rates. This is then forwarded to United Olympic

Life Insurance Company for final approval and implementation. With this three tiered review process, in addition to quarterly review meetings, we feel the rates are actuarily sound and justified.

Enclosed is a worksheet on Mr. Polansky reflecting claims activity since January 1, 1990, through June 30, 1990, in the amount of $5,559.50 in benefit payments. Utilization such as this throughout the entire multiple employer trust necessitated rate increases of the magnitude discussed by Mr. Polansky.

I trust this information will prove helpful to you and if you have any questions, please do not hesitate to contact me.

Sincerely,

/s/ George C. Hurley
George C. Hurley
Manager
Legal Services

GCH/kar

Enclosures

APPENDIX K

Consultants & Administrators, Inc.
P.O. Box 1005
Delaware, Ohio 43015-7105
614-436-6880

March 14, 1991

Paula Anderson, Examiner
Market Conduct
Texas State Board of Insurance
1110 San Jacinto
Austin, TX 78701-1998

Re: MDC #: 05-ANDERSON
Insured: Clifford Lee Cabler
Group #: H14918

Dear Ms. Anderson:

Your letter of February 21, 1991, to United Olympic Life Insurance Company has been forwarded to us as the administrator of the plan of insurance covering Mr. Cabler.

Mr. Cabler is a member of the National Health Foundation Association group which has seen substantial rate increases. We have determined that the benefits for this association have been utilized to such an extent which has required us to increase premiums. The information that is utilized in the calculation of these increases includes the duration of time the individual insured is covered by the plan, his geographic location, and the experience of the entire association.

Based on this data, the Administration Department prepares a trend analysis and forwards it to our consulting actuaries in Chicago, Illinois. Once they have reviewed

the analysis and the background data, a premium is established and forwarded to United Olympic Life for review and implementation. It is then communicated to each individual member of the association. The only other alternative to increasing premiums based on the utilization of the plan, would be to terminate the entire plan which would necessarily leave the membership without health insurance. We have found this latter alternative to be unacceptable.

Concerning the claims questions, we have reviewed our computer claims history and determined that we have provided $16,077.25 in benefits in connection with expenses incurred in October, 1990. Two additional claims are pending as of March 6.

I trust this information will be of help to you and allow you to close your files on this matter.

Sincerely,

/s/ George C. Hurley
George C. Hurley
Manager, Legal Support

GCH/tmp
cc: Allen Berwick
John Brehm

APPENDIX L

[seal]

United Olympic
LIFE INSURANCE
COMPANY
A member of USLICO Corporation
P.O. Box 90055 –
Bellevue, Washington
98009 –
(206) 451-7441

United Services Life
Insurance Company
Bankers Security Life
Insurance Society
Provident Life Insurance
Company
United Olympic Life
Insurance Company
United Services Equities,
Inc.
USLICO Securities
Corporation

April 16, 1991

Ms. Paula Anderson
Examiner
Texas State Board of Insurance
Consumer Services 016-5
1110 San Jacinto
Austin, TX 78701-1998

Re: Insured: Clifford Lee Cabler
MDC#:05-Anderson

Dear Ms. Anderson:

Mr. Cabler is a member of a closed block of business. There are only 20 members currently residing throughout the country. The claims on this group have been extremely high, and continue at levels much exceeding the premiums. Since inception, this block has had claims more than double the premiums. For those currently insured, the claims of $670,843 through February 1991

have greatly exceeded the total premium income of $177,360.

It is our opinion that the recent rate increases are justified. The rate increases attempted to place all insured's [sic] at the same rate level, reflecting age/sex/geographic factors. However, various state regulations have made both the timing and amount of increases vary. All rates of policyholders in Texas were increased at the same time. All rates were increased to the same percentage of rates used for new issues for other association business as the block is too small to allow proper rating by age/sex/geographic location.

Sincerely,

/s/ James Knight
James P. A. Knight, FSA, MAAA
Senior Vice President and Chief Actuary

JPAK:ew

APPENDIX M

Delaware Administrators, Inc.

P.O. Box 1005
Delaware, Ohio 43015-7105
(614) 436-6880

April 10, 1992

Mr. J. Bennett White
Wilson Sheehy, Knowles, Robertson & Cornelius
315 East Fifth Street
Tyler, TX 75701

RE: United Olympic Life Insurance Company –
Michael Hogue

Dear Mr. White:

I am responding to your letter to Mr. James J. Hagerty of December 16, 1991.

Mr. Hogue was not singled out individually in this action. The entire group of people in the same class (same: age/sex/geographic location/benefit package) were subject to the same actions.

The premium increases were based on the experience of the group. I have attached a copy of the experience with developed claims calculated for your information.

Benefit changes were required for all policyholders and proper notice as required by Texas Insurance code was given to all policyholders.

The above referenced policy terminated for non-payment of premiums effective January 31, 1991; however, the rate increase was not effective until March 1, 1991.

Please advise if you have any questions or require any additional information.

Sincerely,

/s/ Sheryl A Owen
Sheryl A. Owen
Director of Administration

SAO/bal

cc: James J. Hagerty
Francis Podlesney

Encls:

[Attachment Omitted in Printing]

APPENDIX N

Consultants & Administrators, Inc.
P.O. Box 1005
Delaware, Ohio 43015-7105
614-436-6880

VIA FACSIMILE

November 28, 1990

Mr. Thomas G. Smith
Supervising Investigator
State of New Jersey
Department of Insurance
Division of Enforcement and Consumer Protection
CN 329
Trenton, New Jersey 08625-0329

Re: Murtagh Morgan
Policy No. 0400069290
Your File No. 90719

Dear Mr. Smith:

It was a pleasure speaking with you over the telephone yesterday regarding this complaint. We appreciate this opportunity to respond to Mr. Morgan's concerns.

In his letter of September 30, 1990, to the Department of Insurance, Mr. Murtagh indicates that he has seen a list of insureds who have been "singled . . . out with an asterisk." I can assure you that no one has been "singled out." Every producing agent was provided by us with a list of his or her insured employer units. The groups shown with an asterisk were those persons whose coverage is through the Med Preference Trust. This Ohio-based multiple employer trust has shown increasingly high benefit utilization, leading to rather large rate increases in the

past. In order to attempt to hold down the latest premium increase, it was decided by the actuaries for the carrier, the administrator and the reinsurers to increase each insured's co-insurance percentage. Thus, the people shown with an asterisk on the list provided to each agent had their co-payment increased from 20% to 40%. This allowed us to reduce the still rather large premium increase by an appreciable amount.

We can assure Mr. Morgan that no insurance company has done anything illegal. In addition, his group was not singled out because of his son's condition. Rather, the entire Ohio multiple employer trust received the same increase in its health insurance premiums.

Mr. Morgan also contends that he has been harassed in connection with his submission of claims on his son. Let me assure you that the pre-existing condition investigation which was commenced when the claim was filed was purely routine. This type of investigation is done on all initial claims for sicknesses which might have commenced or been treated prior to the effective date of coverage. Once it was determined that the condition did not pre-date the coverage here, benefits were provided.

As explained above, premium increases have been significant for insureds under the Med Preference Trust. An alternative to increased premium and slightly lower benefits would have been to cancel the entire block entirely. We felt the latter course of action would have had a much greater impact on those persons insured under the trust. Thus, the decision was made to maintain coverage, but with a slightly different benefit structure and a concurrent increase in premium. Had the decision been made to

cancel coverage, Mr. Morgan's group would have found themselves in the unfortunate position of probably not being able to re-qualify for coverage through United Olympic Life. At least as far as our decisions have affected the Morgans, there is no doubt that they still have valuable insurance coverage, and no new pre-existing period to meet.

No one can predict what will happen in the future. Hopefully, the recent changes in the Med Preference insurance program will eliminate large future premium increases. No matter what occurs, we can assure the Morgans, as well as the department, that we will make every effort to service their life and health insurance needs as best we can. If we can be of any further assistance to you, or to the insureds, kindly let us know.

Sincerely,

/s/ Bennett L. Katz
Bennett L. Katz
Senior Vice President
General Counsel

lam

c: James Hagerty
James Knight

APPENDIX O

SPECIALIZING IN EMPLOYEE BENEFITS
(Logo)
RISK FUNDING
ALTERNATIVES, INC.

September 29, 1989

Dear Customer:

RISK FUNDING ALTERNATIVES, INC. is proud to announce our affiliation with THE BENEFITS FOUNDATION. They are providing, as plan sponsor, a commitment for an "A+ Superior" rated carrier that will assure guarantee-issue of our major medical coverage. This new plan will go into effect on the same day as your present George Washington Life Insurance Company plan ends, assuring continuous major medical coverage.

This change in carriers from George Washington Life is effective November 1, 1989.

Our goal at RISK FUNDING ALTERNATIVES has one purpose . . . "To provide the finest service in the health insurance industry", and adding this "A+ Superior" rated company to our network of coverage brings an extra level of security in these troubled economic times.

Details are being finalized at this moment and additional information regarding your new Certificate of Coverage and ID Cards will be provided prior to November 1, 1989. All claims, regardless of when they are incurred, should continue to be sent to RISK FUNDING ALTERNATIVES at our same address. We will also continue with our same standard Preferred Provider Organization (P.P.O.), Managed Healthcare, Inc.

While many other insurance companies are being forced to announce unreasonable increases in premium and reduction of benefits, we hope you can share in the excitement of a positive development of this magnitude.

And, before the end of the year, we will announce the development of new options to help control your health insurance cost, while maintaining quality service.

In summary, RISK FUNDING ALTERNATIVES assures the continuation of the same level of excellence in claim services but now with the added security of an insurance company that has enjoyed an A.M. Best "A+ Superior" rating for many years.

Thank you for allowing RISK FUNDING ALTERNATIVES to service your insurance needs. Should you have any specific questions concerning this transfer of coverage, please call your agent or RISK FUNDING ALTERNATIVES.

Sincerely,

/s/ Tom W. Slack
Tom W. Slack

sb

APPENDIX P

SPECIALIZING IN EMPLOYEE BENEFITS
(Logo)
RISK FUNDING
ALTERNATIVES, INC.

October 13, 1989

Dear Insured:

This is truly exciting news!
Effective November 1, 1989, your medical coverage will be fully underwritten by an A+ ("Superior") insurance carrier – United Olympic Life Insurance Company (A USLICO Company).

After weeks of comparing companies, we selected United Olympic Life because it has a history of reliability and fairness – and its coverage is backed by more than half a BILLION dollars in assets.

NO STARTING OVER ON WAITING PERIODS OR PRE-EXISTING CONDITIONS – NO NEED TO QUALIFY FOR THE COVERAGE – THE PLAN DESIGN AND RATES ARE SIMILAR.

IF YOU PARTICIPATED IN THE PRESCRIPTION CARD PROGRAM OFFERED THROUGH APC, IT IS NO LONGER AVAILABLE. YOUR PRESCRIPTION DRUG CHARGES WILL BE PAYABLE UNDER THE MAJOR MEDICAL BENEFIT STRUCTURE.

YOUR PROTECTION WILL BE *CONTINUOUS* – JUST AS LONG AS YOU ARE NOT TOTALLY DISABLED OR HOSPITAL-CONFINED ON NOVEMBER 1, 1989, AND YOUR PREMIUM IS PAID ON TIME.

There is *no* application form for you to complete or health questions to answer. Quite simple:

> Complete a simple Participation form which will be provided by your agent.
>
> For any covered accidents or illnesses which occur on or after November 1, 1989, your claims will be the responsibility of United Olympic Life Insurance Company, and processed by Risk Funding Alternatives, Inc.
>
> For any covered accidents or illnesses which first manifested themselves before November 1, 1989, your claims will be the responsibility of George Washington Life, and processed by Risk Funding Alternatives, Inc. in Tyler.

A new Certificate of Insurance is being sent to you. In the meantime, contact our Risk Funding Alternatives office (1-800-777-9066) and/or your Agent if you have any questions.

Sincerely,

/s/ Tom W. Slack
Tom W. Slack
President

APPENDIX Q

SPECIALIZING IN EMPLOYEE BENEFITS
(Logo)
RISK FUNDING
ALTERNATIVES, INC.

October 31, 1989

TO ALL INSUREDS:

As we previously advised you, Risk Funding Alternatives, Inc. is proud to announce its affiliation with UNITED OLYMPIC LIFE INSURANCE COMPANY who has enjoyed an A+ Superior Best rating for many years. This affiliation is effective November 1, 1989, for individuals who are actively at work (or not hospital confined as a dependent) on November 1, 1989.

In addition to your current employee benefits, Risk Funding Alternatives, Inc. has made available to all our clients, *AT NO ADDITIONAL COST,* a VISION CARE CARD which, when presented to participating centers, entitles you to discount prices! Also, Risk Funding Alternatives has arranged for a RxNET DISCOUNT PRESCRIPTION CARD. This prescription card entitles you to purchase prescriptions at a discount of up to 50% without any co-pays! After you've paid for your prescription at the discount, send your charges to Risk Funding Alternatives for processing under your major medical plan benefits. Both of these cards will be mailed to you and your employees within the next twenty days for you to use upon receipt. Enclosed is a brief description of these two new benefits.

By upgrading to an A+ Superior Carrier, we are confident that our future rates and benefits will stabilize. New

booklets will be mailed to you in the next fifteen (15) days along with a supply of forms.

We continue to strive to bring you the best service in our State, a product line that offers you the freedom to choose the benefit package that best suits your particular needs, and the stability of an old, established, financially sound carrier.

If you have any questions, please contact your Agent directly or call Risk Funding Alternatives, Inc.

Sincerely,

/s/ Tom W. Slack, Jr.
Tom W. Slack, Jr.

TWS/kb

Supreme Court, U.S.
FILED
MAY 5 1995
OFFICE OF THE CLERK

No. 94-1657

In The

Supreme Court of the United States

October Term, 1994

MICHAEL HOGUE and CAROL HOGUE,

Petitioners,

vs.

UNITED OLYMPIC LIFE INSURANCE COMPANY, DELAWARE ADMINISTRATORS, and CONSULTANTS & ADMINISTRATORS, INC.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

ANDREW G. JUBINSKY
Counsel of Record
TIMOTHY A. DANIELS
FIGARI & DAVENPORT, L.L.P.
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COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

LIST OF PARTIES

Petitioners: Michael Hogue and Carol Hogue

Respondents: United Olympic Life Insurance Company, Delaware Administrators, and Consultants & Administrators, Inc.[1]

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[1] Pursuant to Sup. Ct. R. 15.2 and 29.1, Respondents certify that United Olympic Life Insurance Company merged into United Services Life Insurance Company ("USLICO"), and USLICO's parent company is Northwestern National Life Insurance Company, which is wholly owned by Reliastar Financial Corp. ("Reliastar"). Reliastar has several subsidiary corporations, all of which it wholly owns other than NWNL Northstar, Inc., a Delaware corporation, and Select Care Health Network, a California corporation.

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RULES CITED:

Tex. R. Civ. P. 162 4

Sup. Ct. R. 10 7

No. 94-1657

In The

Supreme Court of the United States

October Term, 1994

MICHAEL HOGUE and CAROL HOGUE,

Petitioners,

vs.

UNITED OLYMPIC LIFE INSURANCE COMPANY, DELAWARE ADMINISTRATORS, and CONSULTANTS & ADMINISTRATORS, INC.,

Respondents.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Fifth Circuit

RESPONDENTS' BRIEF IN OPPOSITION

Respondents United Olympic Life Insurance Company ("United Olympic"), Delaware Administrators, and Consultants & Administrators, Inc. ("C&A") (collectively, "Respondents") request that this Court deny the petition for writ of certiorari to review the decision of the United States Court of Appeals for the Fifth Circuit entered in this case on December 7, 1994.

STATEMENT OF THE CASE

This is a diversity case decided under Texas law. By way of factual background, Petitioners were insured from November 1, 1989, to January 31, 1991, under a group insurance policy issued by United Olympic to a trust. The trust was established several years earlier for small group employers, ranging from 2 to 50 employees, that would apply for participation in the trust and, if accepted, would obtain group insurance coverage for their eligible employees under the group policy.

Prior to Petitioners' coverage with United Olympic, they had group insurance coverage through two other companies, G.I.C. Insurance Company ("G.I.C.") and George Washington Life Insurance Company ("George Washington"). G.I.C. went bankrupt in the summer of 1989 and George Washington assumed the group coverage. George Washington subsequently notified its insureds, including Petitioners, that it would not provide coverage after October 31, 1989. United Olympic then assumed the entire block of business previously insured by George Washington effective November 1, 1989. Petitioners played no role and had no involvement in the assumption of business by United Olympic. Sometime after November 1, 1989, Petitioners received their group certificate booklet. Michael Hogue was diagnosed with cancer prior to the time United Olympic began providing group coverage.

While insured under the United Olympic group policy, notice was given to Petitioners as well as the other insureds that premiums would be increasing under the policy and certain benefits would be reduced. These

measures were taken in an effort to contain costs and to curtail exorbitant claims submitted under the block of business as a whole. The measures were based on sound actuarial principles and had nothing to do with the characteristics of any particular individual insured under the group policy. Prior to the implementation of the premium increase and benefit change, Petitioners' coverage lapsed on January 31, 1991, for non-payment of premium, and they subsequently obtained other insurance coverage. Despite the cost containment measures instituted by United Olympic, the group policy was ultimately terminated in its entirety on March 31, 1992, because United Olympic suffered devastating losses under the block of business.[2] Petitioners correctly concede that United Olympic had the right to terminate the group policy in its entirety. Incidentally, United Olympic has not offered health insurance since that time.

There is no dispute that United Olympic paid all of Petitioners' claims while they were covered by the group policy, and Michael Hogue's cancer was in remission at the time Petitioners let their coverage lapse for non-payment of premium. Further, even had Petitioners remained insured until the termination of the entire group policy, their medical expenses were less than the premiums they would have had to pay, even without the rate increase.

By way of procedural background, on August 11, 1992, Petitioners filed their original petition in state court,

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[2] C&A was the managing third-party administrator of the group policy until January 1992, and Delaware Administrators assumed that role until the termination of the group policy.

naming as defendants Respondents and Risk Funding Alternatives ("RFA"). Petitioners did not request a jury trial in state court. The Petitioners alleged that Respondents and RFA discriminated against them in the amount of premiums charged and constructively terminated their insurance coverage, and also alleged various other state statutory and common law claims. On September 18, 1992, all defendants removed the case to the United States District Court for the Eastern District of Texas, Tyler Division (the "Trial Court"), on the basis of ERISA preemption. Prior to removal, the Petitioners had voluntarily nonsuited their claims against the only Texas defendant, RFA.[3] However, neither Respondents nor RFA received notice of the nonsuit until after the original notice of removal had been filed. On October 6, 1992, Respondents filed a supplemental notice of removal alleging diversity jurisdiction because of the dismissal of the only Texas defendant. Also on October 6, 1992, Petitioners filed a jury demand.[4] On October 29, 1992, the Petitioners' motion to remand was denied based on the existence of diversity jurisdiction. Petitioners do not dispute the existence of diversity jurisdiction.

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[3] Petitioners filed a notice of nonsuit under Tex. R. Civ. P. 162 which acts to automatically dismiss the claims against the nonsuited party.

[4] Since Petitioners filed their jury demand on the same day that Respondents filed their supplemental notice of removal, the Petitioners' argument that they failed to file a jury demand earlier because they relied on the alleged defective original removal grounds is disingenuous because Petitioners did not receive the supplemental removal notice until October 8, 1992. In other words, Petitioners had no knowledge of the supplemental notice of removal when they filed their jury demand.

On December 14, 1992, Respondents filed a motion to strike the jury demand. The Petitioners filed a cursory response, without supporting authority, arguing that their jury demand was timely because it was filed within ten days of the supplemental notice of removal and under state law practice they would have been entitled to request a jury up to thirty days before trial. These were the only arguments ever raised by Petitioners in the Trial Court regarding their right to a jury. On January 27, 1993, the Trial Court granted Respondents' motion to strike the Petitioners' jury demand, rejecting the Petitioners' arguments as without merit. The Petitioners never again raised any issue regarding their alleged right to a jury with the Trial Court, but rather participated in a bench trial without objection, submitting proposed findings of fact and conclusions of law to the Trial Court after the trial and filing a motion for new trial which did not mention the jury demand issue.

After a two-day trial and extensive post-trial briefing, the Trial Court found that Petitioners should take nothing by way of their lawsuit. Petitioners then appealed certain portions of the decision to the United States Court of Appeals for the Fifth Circuit (the "Fifth Circuit"). On appeal, Petitioners argued, for the first time, that their jury demand was improperly stricken because it was filed within ten days of Respondents' answer (as opposed to within ten days of the supplemental notice of removal). Respondents argued that, notwithstanding that the point of error lacked merit, Petitioners' failure to raise that argument in the Trial Court and participation in the bench trial without objection resulted in a waiver of their right to complain on appeal. Further, Respondents argued

that, even assuming that the Trial Court erroneously denied a jury trial, which it did not, the denial was harmless error since the case could have been disposed of by a directed verdict. As reflected in the Fifth Circuit's opinion, it determined that the Trial Court reached the correct result under Texas law and that no error was committed in the Trial Court's denial of the Petitioners' jury demand. Accordingly, the Trial Court's judgment was affirmed.

REASONS FOR DENYING WRIT

This is a diversity case decided under Texas law. The Petition presents nine questions, seven of which directly involve the interpretation of Texas law. As demonstrated below, the remaining two questions which facially appear to relate to federal law also involve interpreting Texas law and, moreover, were not addressed by the Fifth Circuit in reaching its decision since resolution of the questions was not necessary to the outcome of the case. For these reasons, more fully expanded upon below, the Petition for Writ of Certiorari should be denied.

1. Majority of Questions Presented By Petitioners Deal With State Law

Question numbers 3 through 9 asserted by Petitioners deal with the interpretation of state law. Throughout the Petition, Petitioners argue that the Courts below misapplied various provisions of the Texas Insurance Code and the Texas Business and Commerce Code. *See* Petition pp. 11-19. As this Court stated in *Huddleston v.*

Dwyer, 322 U.S. 232, 237 (1944), "ordinarily we accept and therefore do not review, save in exceptional cases, the considered determination of questions of state law by the intermediate federal appellate courts." *Id.*; *see also Virginia v. American Booksellers Assn.*, 484 U.S. 383, 395 (1988) ("This Court rarely reviews a construction of state law agreed upon by the two lower federal courts"). In the present case, Petitioners bring seven questions involving Texas law, yet do not show that the Fifth Circuit's application of Texas state law is contrary to Texas state court decisions addressing the same issues. *See* Sup. Ct. R. 10 (identifying the character of reasons governing review on writ of certiorari).

For example, Petitioners argue that the Fifth Circuit failed to follow *Union Bankers Ins. Co. v. Shelton*, 889 S.W.2d 278 (Tex. 1994), regarding the duty of good faith and fair dealing. The decision in *Union Bankers*, however, has no application to the facts of this case. *Union Bankers* involved an insurance company's decision to rescind coverage. In the present case, the Petitioners' coverage was cancelled for failure to pay premiums. Further, the Trial Court determined that the Petitioners failed to establish that their coverage had been constructively cancelled, and the Petitioners did not challenge that finding on appeal to the Fifth Circuit. Accordingly, the Fifth Circuit merely made the uncontroversial determination that an insurance company does not breach the duty of good faith and fair dealing by refusing to pay claims which were incurred after the policy lapsed for non-payment of premium. Similarly, with respect to whether "puffing" is an actionable misrepresentation under the Texas Deceptive Trade Practices Act ("DTPA"), Petitioners concede

that one Texas court of appeals has held, consistent with the Fifth Circuit's opinion in this case, that "puffing" is not actionable under the DTPA. *See Autohaus, Inc. v. Aguilar*, 794 S.W.2d 459 (Tex. App. – Dallas 1990, writ denied). Simply because the Texas Supreme Court refused to express an opinion on the issue does not mean that the Fifth Circuit has strayed from properly applying Texas law. Finally, with respect to the remaining questions presented which relate to the proper interpretation of various Texas statutes, Petitioners fail to cite any Texas authority inconsistent with the Fifth Circuit's interpretation of the Texas statutes at issue. In sum, the seven questions of Texas law set forth in the Petition are simply not appropriate for review by this Court.

2. The Remaining Jury Demand Issues Are Not Properly Presented For Review

Petitioners present two questions involving the calculation of time for filing a jury demand in a removed case. However, neither of these questions was addressed by the Fifth Circuit in reaching its decision. This is not surprising for several reasons. First, Petitioners failed to raise the questions with the Trial Court. As noted by the Fifth Circuit in its opinion, "an issue not raised in the district court will not be considered on appeal unless the issue can be resolved as a matter of law and unless failure to do so would result in grave injustice." Petition, A-8. Second, as Respondents argued to the Fifth Circuit, the Petitioners waived their right to a jury by, among other things, participating in a bench trial without objection. *See White v. McGinnis*, 903 F.2d 699, 703 (9th Cir.) (en

banc), *cert. denied*, 498 U.S. 903 (1990); *Southland Reship, Inc. v. Flegel*, 534 F.2d 639, 644-45 (5th Cir. 1976). Finally, as Respondents also argued to the Fifth Circuit, the error, if any, in striking the Petitioners' jury demand was harmless since the case could have been disposed of by directed verdict. *See, e.g., United States v. Williams*, 441 F.2d 637, 644 (5th Cir. 1971) ("this court does not demand jury consideration of an issue which is determinable by directed verdict"); *In Re N-500L Cases*, 691 F.2d 15, 25 (1st Cir. 1982).[5]

Given these arguments made to the Fifth Circuit, the statement in its opinion that "having reviewed the entire record and the applicable law, we find no error in the district court's denial of the Hogues' jury demand" clearly establishes that the questions presented by Petitioners regarding the calculation of time for filing a jury demand were not relevant in the disposition of the case. Petition, A-8. A review of the Fifth Circuit and Trial Court opinions demonstrates that the case was decided on legal rather than factual grounds. In this regard, Petitioners did not appeal to the Fifth Circuit a single relevant fact finding made by the Trial Court, but rather argued that the Trial Court had misapplied the law to the facts. Recognizing this flaw, Petitioners argue that "the denial of the requested jury has resulted in a gross misapplication of state law." Petition, p. 11. The absurdity of this argument is readily apparent. The federal law questions on which Petitioners seek review were not addressed by the

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[5] Of course, in order to determine if a directed verdict would have been proper in this case, this Court would be required to interpret and apply Texas law.

Fifth Circuit and, therefore, are not properly presented for determination given the facts of this case.

CONCLUSION

The Petition for Writ of Certiorari should be denied.

Respectfully submitted,

ANDREW G. JUBINSKY
Counsel of Record
TIMOTHY A. DANIELS
FIGARI & DAVENPORT, L.L.P.
Attorneys for Respondents
4800 NationsBank Plaza
901 Main Street
Dallas, Texas 75202
(214) 939-2000
(214) 939-2090 (FAX)